S. HRG. 102–1160

ACCESS TO HEALTH CARE FOR THE ELDERLY: "WHAT IS BEING DONE TO ADDRESS BARRIERS TO ACCESS, AND WHAT MORE SHOULD BE DONE?"

HEARING

BEFORE THE

SUBCOMMITTEE ON AGING

OF THE

COMMITTEE ON LABOR AND HUMAN RESOURCES UNITED STATES SENATE

ONE HUNDRED SECOND CONGRESS

FIRST SESSION

ON

EXAMINING THINGS THAT ARE BEING DONE IN MISSISSIPPI THAT COULD BE EMULATED BY OTHER STATES OR USED AS MODELS FOR FEDERAL EFFORTS TO ADDRESS PROBLEMS OF HEALTH CARE ACCESS

MAY 1, 1991
CLARKSDALE, MS

Printed for the use of the Committee on Labor and Human Resources

U.S. GOVERNMENT PRINTING OFFICE
80-946 CC WASHINGTON : 1992

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-044613-9

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WEDNESDAY, MAY 1, 1991—Clarksdale, MS

APPENDIX

ACCESS TO HEALTH CARE FOR THE ELDERLY: "WHAT IS BEING DONE TO ADDRESS BARRIERS TO ACCESS, AND WHAT MORE SHOULD BE DONE?"

WEDNESDAY, MAY 1, 1991

U.S. SENATE,
SUBCOMMITTEE ON AGING, OF THE COMMITTEE ON LABOR AND HUMAN RESOURCES,
Clarksdale, MS.

The subcommittee met, pursuant to notice, at 9:36 a.m., in Clarksdale Civic Auditorium, Clarksdale, MS, Senator Thad Cochran, presiding.

Present: Senator Cochran.

OPENING STATEMENT OF SENATOR COCHRAN

Senator COCHRAN. If the hearing will come to order, please, we will get started. I want first to express the appreciation of our committee to the city of Clarksdale, and Mayor Henry Espy in particular, for arranging for our use of the city auditorium for the hearing. So our first order of business is to formally thank the mayor.

Mayor, if you would come forward to the witness stand and let me express in behalf of our Aging Subcommittee of the U.S. Senate the appreciation to you and your staff and the citizens of the city of Clarksdale for letting us come here today to this facility and to conduct our hearing on access to health care of elderly citizens. I am glad that you could be here to let us express these words of appreciation to you. Thank you very much for all you have done to make this a possibility for us.

STATEMENT OF HON. HENRY ESPY, MAYOR, CLARKSDALE, MS

Mr. ESPY. Thank you, Senator. Good morning, first of all, to your staff and to the visitors here who have come into our city. On behalf of 23,000 Clarksdalians, welcome to our community, and we would like to wholeheartedly thank you for choosing Clarksdale as the site to hold these elderly health care hearings.

I am sure that this hearing will highlight many things about Clarksdale and Coahoma County and Mississippi and what we are all doing to improve and promote the better health care for the elderly and to bring about an atmosphere of a better quality of life that we all would like to achieve.

Senator, if you would permit me 1 minute to give you a brief message about what Clarksdale is doing for the elderly. I would like to express that at this time.

The city of Clarksdale, Senator, has one of the lowest—the lowest—homicide rates in the Nation. Last year, while records were being set in the Nation for homicides, the city of Clarksdale had only two deaths. These two deaths represented one-tenth of 1 percent of the national average, which was over 23,000 cases. Senator, as of this present moment, the city of Clarksdale has not experienced one single homicide for this year of 1991.

Now, besides the good medical facilities that we have, that is what city government does for health care. We provide a safe, a sound, and a wholesome environment for our senior citizens. On behalf of a safe city, Senator, a sound city, and a wholesome city, 23,000 citizens have empowered me with the privilege of awarding to you our most treasured possession, the key to our city. Once again, thank you for choosing Clarksdale.

Senator COCHRAN. Well, thank you very much, Mayor. I appreciate the opportunity to receive the key to the city. Thank you. Thank you very much. [Applause.]

That is a nice way to start the hearing, and I appreciate very much the mayor's being here. I also appreciate the assistance of Mr. Eddy Rolling, who has helped in the arrangements and in our preparation for the hearing. Many of you who are here have also been a big help to us, particularly those who are going to testify as witnesses at our hearing today. I want to thank you all for being here and helping in the way that you have.

The hearing today is conducted under the auspices and with the authority of the Subcommittee on Aging of the Labor and Human Resources Committee of the U.S. Senate. I serve as the ranking, or senior Republican member of that subcommittee. Senator Brock Adams of the State of Washington is the chairman of the subcommittee, and it is under the authority of his chairmanship that we are authorized to conduct the hearing today here in Clarksdale.

Today we are going to discuss access to health care for the elderly. One of the duties of our subcommittee this year is to report with recommendations to the full committee our suggestions for reauthorizing the Older Americans Act. Many hearings have been held in Washington and elsewhere in the country, looking at ways that we can improve the programs that are administered under the authority of the Older Americans Act.

A few years ago, in connection with my duties as a member of this subcommittee, we had a meeting in Tupelo, where we explored some of the problems that older Americans and older Mississippians have in trying to get access to health care services and facilities. This hearing gives us an opportunity to follow up on that initial hearing of 1988 and look at some of the positive things that are happening here in Mississippi to help assure greater access of older citizens to health care facilities and health care services.

This is obviously a very broad and complex topic, and we are not going to be able to discuss every aspect of it in great detail in a 3-hour hearing. But it is important that we talk about it and that we try to put our heads together and explore the options for dealing with and solving the problems associated with access to health care. We want to know what is currently being done in our State to break down whatever barriers do exist in health care access for older citizens and what else should be done, especially at the Fed-

eral level in connection with our responsibilities for legislating health care programs.

We are especially interested in those activities that might be emulated by other States and also that could serve as prototypes for Federal programs.

We will hear from three panels today. The first panel will be made up of publicly supported providers, including State and Federal health officials as well as the director of a community health center which is partially supported by the Federal Government. Our second will consist of private service providers representing physicians, nurses, long-term care facilities, and hospitals. Our third panel will be the third-party payers, those who primarily pay for the health care needs of our citizens, including Medicaid, Medicare, and the private sector insurance industry.

I think this approach will give us the benefit of various perspectives on how we can improve access for older citizens to health care products and services. Members of Congress and the Administration are spending a great deal of time these days discussing the serious situation confronting all citizens in health care costs and problems with availability of health care services. I am sure this is an issue that is going to gain increasing attention, especially as our population ages. There is a sense that if we don't act now to deal with this situation, it will become much harder to manage in the future.

I hope our witnesses today will help us with suggestions and ideas and their recommendations to our committee as to what we can do or what we should help encourage the Administration to do to improve our current system of health care services and how we can help fill in the gaps that currently exist in providing adequate and affordable health care services for older Americans.

Senator COCHRAN. Let me at this time then welcome our first panel of witnesses and ask you to come forward to the witness table: Dr. Alton Cobb, who has served our State as its State health officer for many years. He is recognized as one of the most knowledgeable and capable authorities on public health in the United States. Dr. Randy Hendrix, who is executive director of the Mississippi Department of Mental Health. Dr. L.C. Dorsey; Dr. Dorsey is director of the Delta Health Clinic in Mound Bayou, a community health center supported, in part, by the Federal Government. And Mr. Robert Jackson; Mr. Jackson is director of the Division of Community Health Services of the Public Health Service Region IV office in Atlanta, GA.

We appreciate very much this panel providing us with written statements that will be included in the record of the hearing. We ask you, as part of our effort to get all of the testimony within the time frame we have available, to summarize your statements, if you can, for us. And then we will have an opportunity to discuss your statement.

Dr. Cobb, welcome. I hope you will proceed to be our leadoff witness.

STATEMENTS OF ALTON B. COBB, M.D., STATE HEALTH OFFICER, MISSISSIPPI DEPARTMENT OF HEALTH; A. RANDEL HENDRIX, EXECUTIVE DIRECTOR, MISSISSIPPI DEPARTMENT OF MENTAL HEALTH; L.C. DORSEY, D.S.W., DIRECTOR, DELTA HEALTH CENTER; AND ROBERT JACKSON, DIRECTOR, DIVISION OF COMMUNITY HEALTH SERVICES, REGION IV, U.S. PUBLIC HEALTH SERVICE

Dr. COBB. Thank you very much, Senator Cochran. It is certainly for me, and I am sure for all of us, a pleasure to be here and to provide information based upon our experiences in the State as to how nearly we are meeting those goals of assuring that all of our elderly have access to a good health system.

We are all aware that we have an increasing aging population. The first point I wanted to make is that the aging never, or almost never, reach the point that they themselves can't do things that will improve their health outcomes in terms of prevention. In terms of changing behaviors, stopping smoking, good nutrition, reducing sodium intake, and increasing physical activity and losing weight are some of the things that many of our elderly, particularly those who are just beginning to advance into the elderly age group, could be concentrating on. And they need our help and encouragement in those areas.

The next area is the access to good primary care. In that regard, let me emphasize in particular the importance of primary care that emphasizes prevention; preventions such as the control of high blood pressure. And in Mississippi we do have an unusual prevalence of hypertension due to the fact that we have a high percentage of minority population and hypertension is more commonly found among black citizens. We have more diabetes. There is a lot more we need to do for early detection and treatment through good primary care of those conditions.

There are many screening tests that we could be utilizing more effectively. We are in some instances. We need to expand our screening among women for breast cancer with mammography and prostate cancer in men.

Next is immunization. And I guess there is nothing more fundamental in prevention than immunization. Immunization against pneumonia and influenza. As I already mentioned, counseling to promote healthy behaviors, and good primary care to deal with these conditions, are very important.

A comment or two about what our agency, through its local health departments, is attempting to do to address some of these issues. We do provide screening and treatment services for both hypertension and diabetes. However, we are limited in our ability to reach out to all of those who need our service. This past year we served approximately 3,300 persons with hypertension and some 1,192 diabetics. This was done in cooperation with the private medical community in our locations where our health departments are located.

A little plug here for something pending in Congress that I know in addition you have a good bit to do with, a lot to do with. These services that we are funding for hypertension and diabetes are funded, in large part, through our Federal funds through our pre-

ventive health services block grant. That block grant program now is at around $100 million.

A proposal is pending to increase that to $175 million. If that were possible, we could reach out and serve, in cooperation with private physicians, a large number of the additional hypertensive patients and diabetic patients who do not have other resources and access to care. That would, in my judgment, be a real critical thing that we could do and would do if we had the additional resources.

In terms of immunizations, we have an active adult immunization program. Last year we provided influenza immunizations to almost 50,000 people and pneumonia vaccine to about 8,000. We all know that both of these conditions, influenza and pneumonia, are particularly hazardous for the elderly, particularly the frail elderly. We have worked cooperatively with our nursing homes to try to assure that all persons in those facilities are properly immunized.

About 25 percent of the frail elderly—that is, those over 85—have limitations in their ability to function, to do those activities of daily living. Few of our elderly, unless they are eligible for Medicaid, can afford long-term care. As you know, the affordability of long-term care, nursing home care, is a national issue. I would like to put it in the record here that that is an issue that this Nation needs to grapple with and find some way to solve, so that as our population ages, our people can have a basis for payment for adequate long-term care.

Home health services are a very important part of the spectrum of services to address the needs of particularly the home-bound elderly. We are one of the agencies that provides home health. There are a number of private agencies. This is a service that has been growing by leaps and bounds. Last year the increase in our visits was over 50 percent. I am sure that this is a valuable service, we know it's a valuable service, but there are still persons who somehow don't fit exactly the home health criteria. Senator, as you recall, you were helpful to us in gaining approval for some authority for a different level of home health service. In our State this is called Project Home. Under this, we are able to serve some additional persons who would not otherwise be eligible for home health services. And in that particular project area, I think that's meeting the needs of a fair number of elderly who otherwise would be handicapped in not having that service.

There are gaps in homemaker services and other social services. These services are provided with support through our Department of Human Resources and the Council on Aging. We all know that social isolation is both a risk factor for disease and a measure of reduced functional independence. Social support networks are influential in fostering the health and independence of elderly persons.

Depression—and I am sure Dr. Hendrix will mention this problem—is a particular problem among the elderly. Men age 65 to 74 have the highest suicide rate in our Nation. That is, I suspect, a result of the difficulties in adjusting sometimes to retirement, adjusting to changing life styles, adjusting to health problems, and social isolation.

The Council on Aging, I know, is going to give a written statement, but I had a note or two on some of their services because

we have worked so closely with them. Last year the Mississippi Council on Aging, using funds under the Older Americans Act, provided almost 5 million units of service to about 85,000 clients in Mississippi. You know, this is very impressive because I think our total numbers of elderly in this State are, what, 250,000 or so. These included in-home services to almost 10,000 people, community services to 66,000. Three million meals were served. That's a lot of eating. And 1,200,000 of those were in congregate sites, and particularly in my interest, almost 2 million were at home because so often to provide the meals at home in conjunction with homemaker in-home health makes for the full spectrum of service. It makes it possible, with the family support, for the elderly person to remain at home.

We all know that for many, however, nursing home care is necessary. You will hear testimony from the representatives of the nursing home industry in Mississippi. We continue, however, to have a shortage of nursing home beds in this State. This is mainly due to the fact that our legislature has put a ceiling on the number of nursing home beds in order to limit the expenditures under the Medicaid program. However, there are additional persons needing that service, and somehow I think we need to try to find a way through that dilemma at this time.

One other area that I wanted to emphasize is the area of geriatric medicine in regard to primary care. We have in our Nation very few physicians who are trained in geriatrics as a specialty. In addition, frankly, in my judgment, our medical schools and residency programs have not been doing a very good job in emphasizing geriatrics as a part of the curriculum in their medical school curriculum and in their residency programs in primary care.

This is reflected in the fact that it is very difficult to get physicians interested and motivated to serve patients in our nursing homes. Another factor that relates to that is the low rate of reimbursement for physicians to visit patients in nursing homes.

Senator, I think you are aware of the development of the RVS fee system that is now being worked on. I saw a paper recently that showed among all of the physician services that have been ranked, the payment for a physician to visit a patient in a nursing home was the lowest-paid, relative to value and other services, of all physician services. So, here we are concerned about access of patients to nursing homes and to good quality physician service, and yet we really don't compensate the physician adequately to make that possible.

One other area that I think could be emphasized more is that of geriatric nurse practitioners. We utilize nurse practitioners extensively in Mississippi. We have one training program for geriatric nurse practitioners. It is my opinion that more geriatric nurse practitioners could be utilized very effectively in nursing homes to help fill this gap for health supervision in the absence of physician coverage.

I have some notes in my report on the Geriatric Education Center in Jackson, which I know you are familiar with. I have some notes dealing with the expansion of Medicaid to additional elderly, which I am sure Ms. Wetherbee will comment on more extensively. This is going to be very meaningful and very helpful to us.

In closing, I would like to thank you for your interest in this area of health care and your interest in all aspects of health care as we have worked together over the past several years and I have worked with your fine staff. I have appreciated the opportunity of working with you and with them on advancing the welfare of people in Mississippi to gain better access to health care. Thank you for allowing me to be here.

[The prepared statement of Dr. Cobb appears in the appendix.]

Senator COCHRAN. Thank you, Dr. Cobb. We appreciate your being our leadoff witness today. I think you have set the tone for the hearing very nicely and touched on a lot of different aspects of this issue area. We appreciate your being here. Thank you very much for your testimony.

We will now hear from Dr. Randel Hendrix.

Dr. Hendrix.

Dr. HENDRIX. My presentation will have four points to it. I will speak briefly about some statistical data related to mental health and the elderly; second, I will speak about some of the research efforts we have done in the State to try to get a hold of this problem; third, the services we provide now; and fourth, some recommendations about what needs to be done.

Statistically, the incidence of mental health problems among the elderly has been reported to be higher than in the general population. Specifically, worldwide, the elderly lead the World Health Organization's list of new cases of mental illness. There are 236 elderly per 100,000 who suffer from mental illness compared with 93 per 100,000 for other age ranges such as 45 to 64. Fifteen to 25 percent of the elderly in the United States suffer from significant symptoms of mental illness. The highest suicide rate in America is among those age 65 and older. This age group represents 12 percent of the population of the United States but accounts for 20 percent of the suicides nationwide. In Mississippi, the elderly person 60 years of age or older represents 14 percent of the total caseload of the persons seen in our mental health facilities in the community and 20 percent of our caseload of those persons we see in our State psychiatric hospitals, again keeping in mind the figure of 12 percent as their representation within the population.

Two things that we have tried to do in the State: In 1985 and 1986 we set up an interagency task force on the elderly with mental handicaps, and they published their findings in a publication on June 1, 1986, entitled "Elderly Mentally Handicapped Mississippians: A Coordinated Plan." It has a wide range of services that are needed by the mentally ill who are also aged, outlined in that publication.

Second, as a part of the State's requirement for a State mental health plan, the Department of Mental Health established in 1989 an elderly task force as part of the Mississippi State Mental Health Planning Council. It has an ongoing function to evaluate and update what the needs of this special population are. The chairman of that task force, Senator Cochran, lives here in Clarksdale, and I believe he is in the audience, Mr. Newton Dodson, who is head of the local mental health center. He is head of the State's elderly task force on the State Mental Health Planning Council.

They now are in the process of holding 10 small regional meetings around the State, and with the help of Dr. Cobb and other State officials, we are having representation from the Health Department, the Mental Health Department, from the Council on Aging, from the Economic Planning Districts, from Medicaid, from the health centers such as the one operated by Dr. Dorsey, to try to come up with the parameters of services that are available within given districts.

The reason we are doing that is that we find that old people like Dr. Cobb and myself, who have been around 20 years, know how the system works and we can pretty well help a person if they contact us directly.

One of the parts of these meetings is to allow the people on the local level to become familiar with one another at all ranges of administration so that we have an oncoming group of professionals and paraprofessionals that know the network of services within the State. These task forces, the 10 regional meetings, in addition to coming up with a finalized report, serve as self-trainers, cross-training for those persons interested in the mentally ill and the mentally handicapped elderly citizen.

What are we doing now in Mississippi? The State has two primary modes of service for persons who are elderly: A person that is elderly that is acutely psychotic is usually treated in a State psychiatric hospital located at either Meridian or Whitfield, just outside of Jackson. The majority of the elderly that we serve, however, are served through our community mental health centers, such as the one located here in Clarksdale and in other major cities throughout Mississippi.

These facilities, the community centers, provide individual therapy, which can consist of counseling with the person, or they provide individual therapy in terms of meeting with the physician to monitor the medication that a person is taking. We have some specialized day programs and services for the elderly—not enough, but some. And we have those generic services one finds in a mental health center, individual therapy, group therapy, and the counseling therapies, as well as case management to assist people with problems outside the environment of the mental health center itself.

We also have cooperative relationships with most of the nursing homes throughout the State to do the screening for persons in nursing homes who might also have a mental illness and to provide mental health therapies for those persons who are in nursing homes.

What are some of the recommendations: Of course, we always list the one, coordinate existing services. Mississippi is fortunate. Mississippi is a rural State and we are a poor State, but there are advantages to being a rural State in the fact that everyone seems to know everyone else. There is very little turf fighting, and the people are willing to cooperate in almost any way that you request of them to maximize what limited resources they have available. I guess it's that we have a spirit of being a home, one big home that just happens to be an entire State.

The second thing is that we need to increase the access of existing senior services by the elderly. In some instances, we have serv-

ices but certain portions of our population aren't aware that they exist. We have a number of persons in Mississippi who, through no fault of their own, are not extremely sophisticated academically and sometimes the service exists in their hometown but they are not aware that it exists.

A third thing is the elimination of institutional barriers. What I mean by that, sometimes we have inherent rules that preclude the efficient delivery of services. One which I am sure the people from the nursing homes are going to speak about is we have an Omnibus Budget Reconciliation Act which was passed in 1987, and it had some very good things in it:

One, they started requiring that persons not just be placed in nursing homes if they needed mental health treatment, they had to have physical impairment. But the requirements to evaluate a person to make sure they don't have those are so stringent that the end result is that many people who are primarily physically disabled, who just happen to have some secondary mental problem but with whom it's very secondary, their primary problems are physical, that the screening process is so strenuous that many nursing homes give up and accept the more easily manageable patient. This is not done out of a desire not to serve the more difficult one, but by the time they jump through all the necessary requirements of that law, it's just not economically feasible for them.

That is the type of institutional barriers I am talking about. What started out good, as an example, the extreme restrictions for controls that you can place on an elderly person who is in a nursing home who is somewhat out of contact with reality—they wander and they roam around—and the only thing you can do under the new OBRA requirements is put a one-on-one staff member assigned to that person to keep them from roving. So what happens is that person ends up getting a commitment order and being sent to the State hospital, when the person was perfectly well off in the nursing home. That is the type of institutional problem that we would need help with.

Another thing that we would talk about is cross-training. We have many persons that are trained in social work or in the education field or the medical field or in the psychology field, but very little of the curriculum of those different disciplines cross. We have a limited number of persons who are actually trained to work with the elderly population that is mentally ill. There is very little funding for these specialized training programs.

The other thing which I will mention—I won't go through all the recommendations—is day services. There are many persons that are mentally ill that sometimes come to our State hospitals or who end up perhaps in a nursing home who, if there were an appropriate day program, a program that was properly funded, could actually be served during the day in that program and in the afternoon go back to their home when their children get off work; sort of the reverse of child day care. But we don't have funding for that in this State, not adequate funding, and I am not aware of funding at all.

I won't go through the other recommendations we have listed because we have two other speakers. But I, like Dr. Cobb, thank you for taking time to come to Mississippi and give us an opportunity

to speak. I will have to also echo that my staff comments about the fact that no matter what our request for information is, your staff always provides it. I know you might wonder how your staff proceed, but they do respond to both verbal and written requests for information. That is something to be proud of.

[The prepared statement of Dr. Hendrix appears in the appendix.]

Senator COCHRAN. Thank you, Dr. Hendrix. I appreciate those comments and your testimony as well.

Before moving on to Dr. Dorsey, I want to acknowledge with you and Dr. Cobb the presence of Mr. Newton Dodson, who not only is active, as you pointed out, in the task force on health care issues around the State of Mississippi but he also served on the Federal Council on Aging. I recommended him for consideration a few years ago, and he was appointed to that body and of course, in connection with those duties, went to Washington from time to time to attend meetings. He helped to provide guidance and assistance to the Federal-level Administrator on Aging in Washington and other Federal officials and really did an outstanding job. I just want to acknowledge that and thank him for being here today. He adds a little class to this whole operation here by bringing that kind of authority to this meeting.

And Ms. Billie Marshall, who is director of the Mississippi Council on Aging. Dr. Cobb mentioned her and the fine work that they are doing, and the outstanding services that are provided under the auspices of that council. She is a leader in this field as well and has been to Washington from time to time to testify at hearings similar to this one. She does a wonderful job representing our State's interests in those ways.

Now let's hear from Dr. L.C. Dorsey. Dr. Dorsey, as I mentioned, is connected with the Delta Health Center in Mound Bayou. She is well respected throughout our State for the fine work she has done.

Welcome to the hearing.

Dr. DORSEY. Thank you, Senator Cochran, and thank you for inviting me to come and testify before this committee. I would like, on behalf of the Mississippi Association of Community Health Centers and its director, Mr. Robert Pugh, to welcome you to the State of Mississippi and would like to invite you, if you haven't had a chance to stop by one of the 21 health centers in the State, to do this on this trip or some other trip.

Based on the 1980 census for Mississippi, 11.5 percent of Mississippi's population, or 289,000 citizens, were 65 years old or older. Approximately 94,000, or 33 percent of this group, were African Americans. And most of Mississippi's population, as you well know, live in rural areas, and most of the elderly people in rural Mississippi live in poverty. Over 51 percent of African American elderly live in poverty in our State, and 25.7 percent of the white elderly live in poverty.

Now, these two statistics are important when we talk about access to health care. There is no money to pay for it, and transportation becomes a serious barrier. The rural elderly, in addition to living away from service providers and having less money and no insurance to pay for care, are more likely than their urban counter-

parts to be afflicted with chronic illness. Forty-one percent of the rural elderly are constantly under the care of a doctor, or should be under the care of a doctor.

For the rural elderly in Mississippi, there are two major and several minor barriers to health care. The major barriers are economic: money for health care or money to pay the high premiums of health insurance; and transportation to and from the health care provider. The community health center that I am director of provides health care, comprehensive health and dental care, to approximately 60 percent of our patient population who are 65 and older. For those persons who live in rural areas, we pay contracted transportation providers from 94 cents per mile to 75 cents per mile to bring patients to the center. Patients who prefer not to ride a bus or a van to the center often pay from their limited income as much as $40 per trip to come to see a doctor or to see a dentist.

Rural America and the rural elderly are characterized, and perhaps romanticized, as proud, independent, and highly individualistic people. These traits also carry over into health care-seeking behavior and may prevent seeking health care if the perception of charity is attached. Consequently, many of the rural elderly are loath to apply for or seek health care at a center such as ours or other locations that are perceived to take care of the poor or those without finances. Because their value system is centered around payment of their obligations and being true to their word, they are more careful about making debts with private providers or with hospitals.

Approximately 26 percent of the State's population, or 690,000 people, are uninsured, with no protection against the high cost of becoming ill. Only 54 percent of persons eligible for Medicaid, including many elderly citizens, are actually enrolled in the program.

Additionally, there are thousands of people who are eligible for Medicare who fear that they will lose their homes or life savings if they become ill or have to be admitted to the hospital.

Access to health care providers for elderly rural Mississippians is often a major problem. The formula for primary care physicians ratio, adequate ratio, is one primary care physician to 2,000 population. In 1988, this ratio was one physician to 1,600 population. However, 53.7 percent of all of the primary care physicians in the State lived and practiced medicine in eight counties which included the State's large urban areas.

The most popular formula for determining adequate health manpower in an area is to count the number of doctors available versus the number of people who live in the area. This formula does not include the problems of physicians who prefer not to treat Medicaid patients—and there are some—patient transportation problems, child care problems, or patient preference for selecting a provider of their choice. Some physicians are perceived not to be courteous or to be racist or not to care to have poor or nonwhite patients. Whether the perception is true or not, this often causes delay in seeking care in this area.

Many of the rural elderly are nondrivers and are dependent on public transportation, which in our State and certainly in the rural areas, is not the most effective. Therefore, neighbors are often called upon to take them to and from health care. Because many

of them are poor, as stated earlier, or living in poverty and on fixed incomes, the frequency or how often they seek health care is determined by the affordability and their ability to get a neighbor or a church member to bring them to the doctor.

The alternative in this situation is that more and more of Mississippi's elderly are turning to a system of self-care, utilizing over-the-counter medications and products, using herbal medicine and products, and relying to a larger extent on spiritual exercises, such as laying on of the hands and prayer meetings, as an extension of the health care services available to them.

The elderly are a special population who has paid its dues in Mississippi, in the Mississippi workplace, whether it was on plantations, department stores, classrooms, or as domestics or factory workers. They have paid taxes and supported progress for the next generations. They saved money for their retirement, never expecting illness or health insurance to be as expensive as it is today. We owe it to this generation to find a way to meet their health care needs that is efficient, cost effective, and humane.

Preventive health care is offered at community health centers such as the one here in Clarksdale—the Aaron Henry Health Care Center—and at Delta Health Center, the Nation's oldest community health center, located in Mound Bayou, which look at a person's health care needs and look at the family's income and discounts the price of those services to an affordable level. This is the best investment of the tax dollars in the health care field in the last 25 years.

At this point, community health centers do not receive direct funds from the State of Mississippi's legislature for these health care services. But if we received only 5 or 10 percent matching funds with the Federal funds received from Health and Human Services, each center has the capacity, without adding a single staff person, of expanding the scope of services to the frail elderly and the elderly in our communities through outreach program and services and for increased visits to the centers and the centers' health care providers.

Rural Mississippians receive less direct information about disease prevention and health promotion than residents of cities. Health education often is not any more available than doctors to rural residents. The evidence of the need for patient education should be evidenced by comparison to literacy rates. Often, detailed written instructions are given to the patient with the prescription and a 1-minute oral presentation. Doctors at Delta Health Center report incidents of having the patient return to the clinic for follow-up visits only to learn that the medication has not been taken because of the failure to understand both the written or oral instructions. Outreach workers could help with this problem in a very cost-effective way.

One example of a situation which we experience at the health center, which is not isolated, addresses both the literacy problems of our population and the economics. It is demonstrated in this account told to me by a former physician who had a patient on a return visit who had not taken any of one medication that he had prescribed. When he asked the patient why he hadn't taken the pills which he had prescribed to be taken with orange juice, the el-

derly patient patiently explained to the doctor that he hadn't taken the medicine because he had not had any money to buy orange juice.

Community health centers can offer quality health care and health education to elderly rural Mississippians. The cutback in funding over the past few years has significantly curtailed our outreach work in disease prevention and health education. It has also curtailed the ability to send out health counselors to work with the elderly, many of whom are homebound and, as Dr. Cobb indicated earlier, somehow fall through that tiny crack of not being eligible for home care visits.

This, coupled with an improved public transportation system that would not stop at county lines and would not stop at boundary lines where the grant says the service area ended and which had more routes so that a person would not have to wait all day when he got to a center before he could get a ride back home, would really increase patients', especially elderly patients', access to available health care.

Outreach workers who could help patients cut through the red tape and help them understand the access to the services would also be beneficial. Many of the elderly patients simply have misconceptions and have received misinformation about services that are available in their communities, whether those communities are small towns or counties. They simply are afraid and have not had anyone sit down with them and help explain away their problems.

There needs to be some attention addressed to the high cost of medication for the elderly as well as the need for some form of continuous support for those who attempt to live alone in their homes. A Nation with the capability to conquer space and tread on the moon's surface has the potential of removing the fear of becoming ill from all of its citizens. The kinder and gentler Nation that the President has called for should include access to adequate, affordable health care for all Americans, including Mississippi's rural elderly citizens.

Thank you very much.

[The prepared statement of Dr. Dorsey appears in the appendix.]

Senator COCHRAN. Thank you, Dr. Dorsey, for bringing us this important perspective from the rural health centers that we have here in Mississippi. It's a pleasure every year to get to visit with representatives of the organization—Mr. Pugh you mentioned, as director of that group—when they come to Washington. I always look forward to that and always benefit from those discussions.

One of the proposals that is being presented to the Senate, as a serious effort to reform some of our health care programs, has as its centerpiece an expansion of the rural health center concept, with outreach assistance and resources to try to get services and information and counseling to those who are hardest to reach in our society. I think there is no doubt about it that we do have some deficiencies in our system that could be improved if we did a better job with that kind of effort. You have emphasized that in your testimony, and I think it has been very appropriate.

Let us now hear from Mr. Robert Jackson, who is here from Atlanta, GA, representing the Public Health Service's Division of Community Health Services.

Welcome, Mr. Jackson. You may proceed.

Mr. JACKSON. Thank you, Senator Cochran. I will confine my remarks to two basic programs plus one special grant that we feel impact most directly on elderly citizens in Mississippi. I would like to begin by saying there are over 16,000 registered patients who are elderly in the community health centers in this State. That is 10.9 percent of all patients in the health centers. The fact is this is predominantly a rural phenomenon. Four percentage points higher utilization would be seen in rural areas rather than urban ones. In general, the health centers see between 7.5 and 15 percent of all patients who are elderly. The range is considerable. In one urban area, only 3 percent of patients are elderly, in one of the rural centers it is nearly one-third.

Overall since 1987 there has been a 51 percent increase in utilization of health center services by elderly patients in Mississippi. Through 21 grants from funds through section 330 of the Public Health Service Act, PHS provides $18,790,000 each year to the State of Mississippi health centers.

In addition, of course, we are very dependent on Medicaid and Medicare income, and it is with some astonishment, really, sir, that I report to you that since 1986 there has been a 269 percent increase in Medicaid reimbursements to health centers in Mississippi and a 45 percent increase in Medicare reimbursements. This represents substantial revenue for operations and finding new patients and new clinics. An example of the new clinics would be Dr. Dorsey's recent opening of a satellite from Mound Bayou in Greenville, a step we see as highly positive.

In addition to dollars, I would like to point out to you the dependence we have on the National Health Service Corps. As you know, this scholarship program was basically phased out in the early 1980's. Despite that we still have 39 obligated scholars practicing medicine in primary health care centers in Mississippi. Perhaps even more positive, though, is that the health centers themselves have successfully recruited and hired an additional 45 physicians and 15 midlevel providers. So we have a cadre of 99 clinicians staffing clinical services in the health centers.

At the moment, we are trying to recruit an additional 23 providers for the State of Mississippi. In today's world, with competitive salaries and malpractice costs, this is a difficult task. I would like to commend the people in the State Department of Health and the Primary Care Association and the University of Mississippi for their helpfulness and their success in the private recruitment of physicians. We expect probably to fill about half of the 23 slots by the end of this program year.

I made reference, Senator, a moment ago to a special demonstration project; that is, health care services in the home, a grant to the Mississippi Department of Health. This is one of only five such grants in the country. I say with some pride that three of those are in the southeastern States.

I happened to find last week that in just health district 4, that is, the Columbus area, this grant is providing care in the home to over 150 households. And I think it speaks to the successful demonstration in Mississippi and elsewhere of what can be done with a fairly flexible funding source to deal with people who are simply

not Medicare or Medicaid recipients or who don't have those benefits currently available to them in terms of managing disability and preventing institutionalization.

As for the future, in the next few weeks the Federal Register will contain an announcement of new start and expansion activity under section 330. Since this is a national competition, it would be indiscreet of me to forecast the outcome. I intend to advocate strongly for two additional sites in this State in two different communities.

Regrettably, there is no provision currently in the proposed budget for fiscal 1992 for any new start activity or expansion activity in that program.

In addition, during the next few months, my office will be reviewing and making some recommendations on the rural health outreach applications that you mentioned a few minutes ago. We expect 300 to 500 such applications.

A couple of very positive points that have to do with mutual cooperation with other agencies: We have had a cooperative agreement for primary care in Mississippi for nearly 5 years. In the next we are proposing to work with the State agencies and the voluntary and private sectors regarding primary care planning for all counties in the State so that we can jointly, we hope, come to a mutual perception of where the greatest needs are and how we might begin planning and developing to meet those needs.

The second thing I would like to mention is our longstanding relationship between the Bureau of Health Care Delivery and Assistance and the Administration on Aging. Five years ago we began a series of State developmental meetings between community health centers and area agency on aging staff. This has been a very productive endeavor for us. You will notice a few moments ago I said in roughly the last 5 years we have seen a 50 percent increase in elderly users in health centers. I would not attribute to us either cause or effect, but we have tried to be responsive to that.

A few weeks ago in Atlanta we held a regional meeting on health promotion for the elderly, again jointly sponsored by the Public Health Service, the Administration on Aging, and Kaiser Permanente. This was a survey of the current State of technology on disability prevention and life extension, dealing both with the problems of living such as some of the matters other witnesses have already identified, and what is the latest development in health promotion technology and service.

One point about all this, Senator. I think in this State as in several others in the southeast, our principal concern at this moment is the rural, isolated elderly, which I think all three of our other witnesses have spoken to. We have been working through that conference and through some other activities with the historically black colleges and universities, including Tougaloo College here in Mississippi. They have research and practice staff in the area of services to the elderly, and they are helping us develop some program training and resource development for this very problem.

The last thing that I would mention then just quickly is that we have a joint project now with the Centers for Disease Control in our office where we are evaluating new protocols for the management of diabetes, the purpose being, of course, to prevent secondary

consequences such as blindness, amputation, and the like. And we will be field testing those in the next year in a number of health centers in the southeast.

Thank you for the opportunity to comment.

[The prepared statement of Mr. Jackson appears in the appendix.]

Senator COCHRAN. Thank you for your good testimony and for coming over to Mississippi to be with us today. We have enjoyed a good relationship with the Atlanta office, and we hope we can continue to get sympathetic consideration of our requests for Federal funding assistance for these pilot programs. The one you mentioned, up in the Columbus area, we were able to talk about in some detail at a hearing that we held in Meridian on home health services. We had a very good report on the success of it. We hope it can continue to be funded and that the Federal funds remain available for that kind of activity, and we appreciate your help with that.

I wonder, in connection with your comments about the physicians who are Public Health Service physicians who have gone to school with special scholarships that have required them to then practice medicine for a certain period of time in rural areas or with health centers, will the termination of those scholarships severely affect your ability to recruit and retain people in these health centers?

Mr. JACKSON. Following a period of panic, Senator.

Senator COCHRAN. Following a period of panic?

Mr. JACKSON. We take a somewhat more balanced view of the future. We have had success in private recruitment. The National Health Service Corps has been authorized, in lieu of the scholarship program, to have the loan repayment program where we can recruit people to serve. In exchange for a year they receive a certain amount of money to help pay off their students debts. And, of course, given the costs of education today, there are a lot of those people out there. So we see this as an alternative model.

As you may recall, the National Health Service Corps scholarship program was last year reauthorized and expanded. In about 6 years, which at my age I realize isn't that far away, we will see new obligated scholars as well as the loan repayment group. So when I say there was initial panic, I think you can see why. Now I think we see it as at least three strands: loan repayment, scholarship, and private recruitment because the health centers have grown in sophistication and ability and they are becoming more attractive options for clinical practice among well-trained physicians.

One of our concerns, of course, is with reference to the elderly, maintaining an adequate supply of internal medicine physicians, because ultimately that has to be done. And the other area we have considerable concern about is the small number of psychiatrists. I think Dr. Hendrix's commentary about depression and other syndromes in the elderly is not wasted on us. Those are two real concerns. But overall, the picture is becoming more positive.

Senator COCHRAN. Dr. Dorsey, one of the issues that I remember was raised at this year's visit to Washington by health center directors was the issue of claims based on allegations of malpractice and the cost of insurance and some alternative way of providing insurance coverage for health centers and professionals who work there.

Dr. DORSEY. Right.

Senator COCHRAN. Just the other day I agreed to cosponsor a bill that is being introduced in the Congress to authorize a self-insurance program for health centers throughout the country. I wanted you to know about that, and I wanted to ask you whether or not that continues to be a problem and is a bill like this something that you think will be helpful to the health centers if we are able to get that legislation enacted?

Dr. DORSEY. Oh, that would be very helpful. Some of the health centers pay as much as 11 percent of our total budget for malpractice insurance. The Mississippi Primary Health Care Association has lower malpractice insurance at the top of its agenda of items that we need to try to get worked on this year. They are working very hard on trying to find something better.

So, such a bill would help us tremendously. We have tried this before, but you can't get enough in the reserves to protect the health centers. If you have two or three catastrophic illness episodes, you can just be wiped out. And so a bill would really help a lot. It certainly would.

Senator COCHRAN. What about the issue that I was discussing with Mr. Jackson, recruiting and retaining health care professionals, what has your experience been?

Dr. DORSEY. I was listening to his answer. And, of course, he has to speak for all of us here in Mississippi. Depending on where you are in the State, the situation is more favorable. If you happen to be in Edwards, MS, or some place in rural Hinds County, where you're a few minutes' drive from Jackson and the restaurants and stuff there, you have a better chance of recruiting there.

I just had the unfortunate experience of being kicked off the health profession shortage area list for both places, both the center in Mound Bayou and in Greenville. The reason is that in counting the physicians they found 20 primary care physicians in Bolivar County, and I think they counted the folks at the center, and 32 in Washington County, which means we aren't eligible for placements. We are recruiting every day to try to find people, but what you lose in that process is the specialty mix.

Now, we won't have a problem with internal medicine specialists, but we will lose our pediatrician in September, and so far there is not one on the horizon to replace that person. The one whom we were trying to recruit from Nashville got sent to Alabama, although she preferred to come to Mississippi because she's from Mississippi.

So that is the problem we run into: Not only do you lose the specialty mix which is appropriate for health centers since we treat the entire family through all life cycles, we lost that ability, and you wind up with more internal medicine specialists than you need when you'd love to have family practitioners who are becoming more and more rare. And we haven't had an obstetrician in many moons, and there is not even a hint of a promise on the horizon of one coming through. Nurse midwives are very rare and are loath to come to small areas. So the specialty mix is going to be hurt by the shortage of scholars.

Dr. HENDRIX. May I comment on that?

Senator COCHRAN. Sure, Dr. Hendrix.

Dr. HENDRIX. We thought the training of physicians program that used to exist is an excellent program, and we traditionally have kept one or two psychiatrists from that program in our facility in Meridian. Meridian is not a rural area, but Meridian had a low ratio of psychiatrists to patients. We thought the program worked well.

Going along with Dr. Dorsey, sometimes it can look like you're walking in tall cotton when you're really picking it pretty low. In Jackson, as an example, we could never recruit or were not eligible for a psychiatrist through this program at Mississippi State Hospital because your population is taken from the city of Jackson and the city of Jackson has the highest concentration of psychiatrists in the State.

The only problem is the private practicing psychiatrist making over a quarter of a million is not going to work at the State hospital which happens to be in a rural county there, in Rankin County, which is right next to Jackson. So it looked like we have an overabundance of psychiatrists when in fact we have a famine. We didn't have enough.

Senator COCHRAN. Is there some way that we could change that rule? Do we need to modify the legislation or put some language in an appropriations bill? How do we address that?

Dr. Cobb.

Dr. COBB. Senator, in that regard, I had the opportunity recently of serving on a national work group looking at primary care particularly in rural areas. I made a suggestion that as to obstetricians, they should not count for that county, but should count for the service area, because OB has become regionalized. And really what one needs to do is to consider the several-county service area and then relate that to the number of primary care physicians. And Dr. Weaver, who is the director of the National Health Service Corps, has written me a nice letter saying they are taking that under serious consideration. So maybe someone from Mississippi made a suggestion that they are going to pick up on and implement.

Senator COCHRAN. That gives me an idea. This year we are going to be providing funds for that agency in the appropriations process. We ought to put some language in the appropriations bill directing that they take that into account.

Dr. COBB. These services need to be looked at, certain services, from a more regional basis. And also, you need to look at participation in the Federally insured programs, as Dr. Dorsey has made reference to. It doesn't help to have doctors there if they don't see the patients that need to be seen, if they don't take Medicare and Medicaid.

Now, on a positive note, let me mention something that just happened in our State legislature, and I am not familiar with the details on it, but our legislature just renewed and expanded our medical education loan program. And it's my understanding from staff that it's going to be a much more workable program, it's going to be a little bit more responsive, it's going to include both scholarships and loan forgiveness, and they are going to increase the amount that is available for loans as well as for loan forgiveness, for scholarships as well as loan forgiveness.

I think they have the funding for it from the fact that funds have been repaid through the years from the recipients of the program who did not fully fulfill their obligations. I heard a figure of some several million dollars that was available. So I think that is something all of us need to become aware of in Mississippi because that may be a better answer than continuing to look solely just for the Federal help. We need both. We need both the Federal program as well as this new State program.

Senator COCHRAN. Will there be any funds in there for medical education for geriatric specialties? That is a problem that you identified as well as Dr. Hendrix.

Dr. COBB. I don't think that the State program got that specific. But I think maybe that is something we need to work on more with our medical schools and our residency programs. And some of them do get Federal assistance, I think. There might be some ways to create some carrots to encourage that.

In my opinion, that is so badly needed. We see every day examples where patients simply are not seen, particularly in nursing homes, because physicians simply are not interested in that field of practice, or, sometimes when patients are seen, they are not treated appropriately because physicians are just not trained in the fact, for example, that older patients react differently to medications, they can't take as much. There are a lot of things about care of the elderly that physicians need more training in, and they are interested in it but they have so many other areas they're interested in. I think something could be done to strengthen our training programs in our medical schools and offer some incentives to encourage that in our training programs. It would help a lot.

Senator COCHRAN. Dr. Dorsey.

Dr. DORSEY. I just wanted to make one comment about extending the services for obstetrical patients. One of the things that we have suffered from in this part of the Delta is the inability to find physicians who are willing to back nurse midwives. There is some peculiarity that Dr. Cobb probably could talk to more specifically in State law that says a nurse midwife has to be backed by a physician. Nurse midwives and birthing centers, with doctors being encouraged more to participate in this arrangement as they do in Holmes County, for instance, would be very beneficial in helping to extend—this has nothing to do with the elderly—but helping to extend the network of care providers in the community.

Senator COCHRAN. Yes. Well, I think that is a very real problem in that some of those physicians in that specialty have decided to stop delivering babies because of the exposure to malpractice suits and the expense of malpractice insurance. I know personally one physician in Oxford, MS, who just said, " I have stopped. I don't do that anymore."

Dr. DORSEY. That is all over the State.

Senator COCHRAN. "I can't afford to pay the insurance premiums, and I don't want to take the risk." So that leaves either no alternative or a midwife alternative, and then if the midwife is not available, I guess folks are just on their own. That is a sad situation.

Dr. DORSEY. Yes, it is.

Senator COCHRAN. Mr. Jackson.

Mr. JACKSON. Senator, I would like to follow up on your comment regarding the legislation on insurance. In the community health center program, we estimate we are spending 10 percent, or $50 million, a year on medical malpractice costs. This is money unavailable for services, for new starts, for expansions.

One of the pressures on us to recruit physicians outside the National Health Service Corps is obviously we have to pay much higher salaries. The money has to be generated by the health centers to cover that. This is most dramatic for obstetricians but is true for all disciplines. So any relief on the medical malpractice would, I think, ripple very positively into many sectors.

Senator COCHRAN. Well, I think this panel has gotten our hearing off to an excellent start. Your testimony and your perspective is just what we needed to start off this hearing, and I want to thank each of you for participating in the way you have. Thank you very much.

Before we call our second panel to the witness table, I want to introduce some of my staff members who are here today who are helping with the arrangements and the conduct of this hearing. Many of you may think that I just think up all this by myself, and that's not true. I have the very fine and able assistance today of Forest Thigpen, who is sitting with me here at the hearing table. He is a member of my staff in the Washington office and is my legislative assistant with special emphasis in health care and other areas.

Lynnette Moten, who is standing here by the television camera is not a camera person; she is being asked to substitute for one of the news gatherers whose camera person is out doing something else right now. Lynne is in my Washington office; she is from Jackson, MS, and has been a very valuable member of my staff for some time.

Janice Mitchell is monitoring the hearing for my office in Jackson. She provides information and assistance to people with questions about health care issues.

Beth Bridgeforth is here at the table. She is a member of our staff in Washington and is a legislative aide for our Aging Subcommittee.

Martha Scott Poindexter, who is seated behind us here by the flag, taking care of the flag, she is a member of our staff in the Washington office also. We are very happy to have all of them here today assisting us with this hearing.

Let's now call our second panel to the witness table. We have included in this panel: Dr. Shelby Howell. Dr. Howell is an emergency medical physician at the Northwest Regional Medical Center here in Clarksdale. He is here today representing the Mississippi Medical Association.

We have Dr. Mary Pat Curtis, who is a nurse practitioner from Columbus. She is an assistant professor nursing at Mississippi University for Women in Columbus. She is here representing the Mississippi Nurses Association.

Martha Carole White is executive director of the Mississippi Health Care Association, representing long-term care facilities.

Clifford Johnson, who is representing the Mississippi Hospital Association. Mr. Johnson is executive director of the Northwest Mississippi Regional Medical Center here in Clarksdale.

We have written statements from witnesses which will be included in the record of the hearing in full, and we ask you to summarize those written statements and make any comments that you would like.

STATEMENTS OF SHELBY C. HOWELL, M.D., MISSISSIPPI MEDICAL ASSOCIATION; MARTHA CAROLE WHITE, EXECUTIVE DIRECTOR, MISSISSIPPI HEALTH CARE ASSOCIATION; MARY PAT CURTIS, ED.D., MISSISSIPPI NURSES ASSOCIATION; AND CLIFFORD JOHNSON, EXECUTIVE DIRECTOR, NORTHWEST MISSISSIPPI REGIONAL MEDICAL CENTER, REPRESENTING MISSISSIPPI HOSPITAL ASSOCIATION

Dr. HOWELL. Senator Cochran, I have listed my formal testimony as item A to you, and what I am now presenting I offer as a summary and supplement to that testimony.

Access to health care for the elderly is a problem that I feel must be addressed on several levels: local, State, and national. I divide elderly health care into acute care and long-term care. Because of certain tie-ins, rural health care must also be mentioned along with the elderly health care. Mentioning a few statistics: 30 percent of Medicare beneficiaries live in rural America; 25 percent of the general population lives in rural America; 15 percent of all American physicians practice in rural America; and less than 12 percent of medical specialists practice in rural America. Therefore, I cite that, No. 1, there is a disproportionate share of elderly living in rural America when compared to the general population; and No. 2, the limited number of physicians that are practicing in rural America.

A number of things have contributed to the rural health crisis; for example, decreasing industry, the farming crisis, skilled-worker flight. Poverty rates among nonelderly rural residents are 40 percent higher than among urban residents. Rural hospitals increasingly face financial jeopardy, and rural communities continue to experience difficulty attracting and maintaining an adequate supply of physicians.

The situation puts communities, rural communities, in jeopardy, for often there is no alternative hospital at which to seek care and the loss of a rural hospital may mean considerably more than the loss of inpatient care, it may disrupt the local economy.

I will leave further discussion of the rural hospitals dilemma to Mr. Johnson, who is representing the State Hospital Association.

Rural physicians earn less than their urban counterparts. They see more patients. They face higher professional costs, and they have seen their professional expenses rise faster. Why are rural physicians numbers declining? Well, several of the reasons are: isolation in the rural areas, lack of professional backup, decreasing continuing medical education access, spousal employment difficulties, certain cultural and recreational activity restrictions, and concern over rural educational systems.

In a New York Times article last month, 26 States acknowledged difficulty recruiting physicians to serve Medicaid patients in rural

areas versus four States mentioning difficulty recruiting physician in urban areas.

In the same article, with 49 States responding, Mississippi was listed 44th out of 49 States in Medicaid reimbursement for a doctors office visit and last in Medicare reimbursement.

What are some of the solutions to the above problems? Several are: medical student loan scholarships to send more physicians into rural areas, improving continuing medical education access, strengthening out-of-community consultation referral ties, professional liability reform, elimination of the rural/urban physician differential payment rates.

I believe the number of elderly will increase both nationally and in rural areas. The AMA has offered its Health Access America plan to address affordable health care to all Americans. In regard to elderly Americans, this plan recommends: No. 1, enacting Medicare reform; and No. 2, expanding long-term care financing through expansion of private sector coverage. The AMA recommends creating prefunded programs to assure senior citizens continued access to quality health care. I believe that this is already in legislative form under H.R. 2600, by Representative Charles Rose.

On a State level, the Mississippi State Medical Association has worked in conjunction with the Mississippi Council on Aging to develop the senior care program. This program helps low-income Medicare recipients identify physicians who will accept Medicare assignment. Senior care services were provided to over 1,300 patients between January 1990 and February 1991. Additionally, the State Medical Association wishes to encourage an increase in local clinics providing health care to the chronically ill, conducted by county health departments and staffed on a part-time basis by physicians in private practice or retired.

Finally, on the local level, the vast majority of our physicians accept Medicare patients. Many have assisted in nursing home care and several have assisted in working with the county health department system. We are concerned with the recruitment of physicians and the retention of our own medical staff members. We are concerned over the continuing viability of our hospitals and the services that we can offer our patients.

Thank you.

[The prepared statement of Dr. Howell appears in the appendix.]

Senator COCHRAN. Thank you very much, Dr. Howell. We appreciate having the perspective of a practicing physician dealing with some of these real-life problems every day, and we thank you very much for your attendance and your representation of the Mississippi State Medical Association.

Before going into any questions or observations about the substance of your comments, I think we will go forward and conclude with the statements of all members of the panel, and then we will have a chance to discuss some of the statements that you have made.

I would like now to call on Dr. Mary Pat Curtis, representing the Mississippi Nurses Association.

Dr. Curtis.

Dr. CURTIS. Thank you. As the new demographic balance continues to evolve in which the elderly population outweighs the young-

er population, nurses with expertise in gerontology must assume an increasingly important role in the health care delivery system. This role demands a greater degree of autonomy and leadership than has been customary in the past. Gerontology has been a major focus of the nursing profession and has evolved to include both generalists and specialists and requires in-depth knowledge, clinical competence, and decision-making expertise warranted by the complexities of the aging process and unique to each aging person.

The area of specialty with regard to gerontology in Mississippi is primarily represented by nurse practitioners, and as stated earlier, there is one program in the State which prepares this specialist. That is at Mississippi University for Women. Although the State of Mississippi recognizes the nurse practitioner role, it still does not recognize the category of gerontology nurse practitioner. These health care providers are in a unique position to meet the challenge of identifying and implementing innovative, low-cost arrangements for the provision of quality care for elders, including the old-old group.

As a family nurse practitioner with an expertise in gerontology, I believe that we must support all models of health care that are not only looking at disease processes but also at health promotion, including activities of daily living.

I further believe that Federal health policy must be reevaluated so that it allows for the inclusion of gerontological nurse specialists as providers in Medicare and Medicaid programs. The Federal Government has done much to support the education of these specialists, but has virtually excluded these and other nurses from the reimbursement system. It is my further belief that widespread use of gerontological nurse generalists and specialists in a variety of health care delivery settings would realize substantial savings while improving access to health care for the elder.

To substantiate my beliefs, I have chosen to make a few remarks which address the gerontological nurses in our State which are working in primary care in the community health services, home health, and nursing home services. As we know, many elders with chronic problems do not have access to appropriate health services unless a serious problem occurs requiring expensive institutionalized care.

A number of alternative health settings and services provided by nurses, in collaboration with physicians, across the Nation have reduced the demand for expensive institutionalized care.

In our State, as in many States, one alternative health setting is the freestanding health clinic, sometimes called the satellite clinic, sometimes called the rural health clinic, which has been in existence for decades, providing care to the underprivileged and underserved. Mississippi has a few of these clinics, but they are struggling for survival due to the reimbursement issues and lack of physician support.

I would like to say that in Mississippi we have some very successful freestanding clinics. I cite one in northwest Mississippi, where a family nurse practitioner, in collaboration with her physician, has been successfully providing health care to residents in the surrounding area for about 12 years, since her practice site is in rural Mississippi, the majority of her patients are indeed elders.

A variation of this particular clinic is the rural medical clin where physicians, because of their practice settings, are isolat and have little prospect of attracting another physician due to t income and age level of their clients. The nurse practitioner h been invited to join in this practice to manage care particularly f the chronic elder client. I am seeing more physicians who are e couraging nurses to go back to school to get the specialized trai ing. In fact, currently I have two students in our geriatric nur practitioner graduate program who have returned to school so th they can after graduation join a two-physician practice in southea Mississippi. Their primary responsibility will be to monitor an manage elder clients in the community as well as the nursing hom adjacent to the hospital.

Another issue appropriate to chronic illness and health setting i the increase in emergency department visits by elders, which is ad versely impacting efficient utilization of emergency room service For years, researchers have been recommending the development o an interdisciplinary team that would include a nurse with expertis in gerontology to help in the assessment, management, referral sys tem and follow-up of elders. To date, I know of no hospital in Mis sissippi that is currently adding a gerontic nurse specialist. How ever, I do know of specialists in gerontology nursing who are being promoted to go to other States. The one I have in mind has been asked by a large hospital in Memphis to please come and develop her role in the emergency department.

With regard to home care, a major trend, as we well know, has been advocated to keep the elder as independent as possible and at home instead of in the hospital or in the nursing home. Because of the reimbursement system, payment for services in the home is unavailable to many aged who would be sustained in their home with the aid of dependable and ongoing services.

The point also should be made that many elders are homebound not only due to age and failing but stable health, but also to the responsibility of caring for yet another elder. These homebound elders need some assistance with activities of daily living. Most of these services do not require a full-time homemaker or personal attendant nor do they require a nurse, social worker, or physical therapist or physician. However, some mechanism needs to be developed, such as the one that was cited in Columbus, to get these individuals into some kind of a health networking system so that initially and periodically they can be monitored to maintain an acceptable quality of life.

Additionally, the impact of Alzheimer's disease on the elder, family, and community is mandating that health care providers become advocates for programs that focus on those suffering the consequences of these illnesses. Currently, assistance to these people is almost nonexistent. There is a desperate need for respite beds and acute and long-term facilities for affected patients in addition to respite care or help for those homebound caregivers. The latter could be in the form of an outreach program such as mentioned earlier, in which a gerontological nurse, for instance, could coordinate the release of family members for a few hours or even a day.

Another way of looking at respite health in other States has been the use of daycare centers and vacation spots. Implementation of

these respite services have helped to defer or avoid nursing home or hospital admissions.

With regard to nursing home services, the demand, as we know, for nursing home services is expected to increase by 54 percent by the year 2000 and by 132 percent by the year 2030. About 80 to 90 percent of the health care problems that occur among nursing home residents could be managed by a gerontic nurse specialist as an alternative to the physician.

This specialist in geriatric care is an integral member of the nursing home system and can, in her role, function to decrease incidents and accidents, decrease transfers to acute care system, decrease medication usage, increase functional capacities of residents, and positively influence staff and patient morale.

I believe that elders are not well served in the present health care system and that nurses, especially gerontological generalists and specialists, can do much to improve this dilemma.

In addition, I believe that the public is not fully aware or fully familiar with the health care options, such as perhaps reliance on nurses instead of physicians for some of the basic health care and home-based health care. Nurses are fully licensed and have been granted credentials by professional organizations to provide the services within the scope of nursing practice, and the specialist in these areas can indeed do things such as perform physicals and psychosocial evaluation. They can monitor and manage common acute and chronic stable health problems, and some States recognize prescriptive rights, as does Mississippi. They can collaborate with the patient, the family, and certainly with the physician in coordinating goals for the patient. They can counsel, they can educate, they promote preventive care, and they collaborate with other health disciplines.

And if our approach to elder health care is going to be interdisciplinary, this particular person is a valued member of that team. The services that he or she provides should be eligible for third-party reimbursement. Therefore, I believe that the Federal Government should consider encouragement of a long-term care insurance program to maintain elderly people in their homes and communities.

I further ask that we consider support of tax credits to offset dependent care expenses incurred by families who care for dependent elders in their home.

I would ask that we clarify and strengthen the education system for nursing by securing increased appropriations for the Nurse Education Act. Financial incentives are also needed for education and retention of faculty. We also are dwindling and aging, and there is nobody replacing the faculty.

Support legislation, please, that would provide educational opportunities for all individuals who deliver care to the vulnerable and underserved, both in the rural and urban areas.

I ask that nurses be appointed to committees involved in making rules and regulations that affect the health care system. This action would greatly strengthen the interdisciplinary approach mandated in care for the elder.

Consider, please, the development and/or support of amendments to all Federal insurance programs and health care initiatives that

would allow for family care dependent elders, disease preventi and health promotion programs, and reimbursement of nurses f their services.

I ask that you would consider the development and support nursing home legislation that would increase or strengthen t Medicaid language.

And I also look for help in funding nursing research focused care of the elder. This action would stimulate improvement of exis ing interventions and development of innovative approaches a dressing issues related to the elder citizen.

Further, it would promote the inclusion of the nurse research participation in existing advisory boards for grant and servi awards.

I thank you for this opportunity to share my testimony.

[The prepared statement of Dr. Curtis appears in the appendix

Senator COCHRAN. Thank you, Dr. Curtis, for your very helpfu perspective, and I appreciate your comments very much.

Now we will ask Ms. Martha Carole White for her comments representing the Mississippi Health Care Association.

Ms. WHITE. Thank you, Senator. The Association does represen about 75 percent of the State's nursing facilities. Now, that woul include the public facilities, private facilities, hospital-based nurs ing homes, and freestanding nursing homes. That does include th facilities for the mentally retarded and the facilities for the geri atric patient. Despite the fact that it includes all of these, Senator our problems are the same at every level of nursing home care. The face of nursing home care, we feel, is a very unique face becaus it does combine and include all the acute care services that we have been hearing from today. The long-term care nursing facility is a medically oriented mix which must include the social work services, counseling in matters of life and death, nutrition, and constant involvement in guarding the patient's rights.

Because we are what we think is unique, we do have our own ideas as to what constitute barriers to this care. I have three that I would like to name. The first one is the reluctance of Government and health care advocates to recognize and acknowledge the difference between acute care and long-term nursing facility care. That problem does not exist with this panel or with the people who are speaking today. We all understand the difference.

But the elderly people in the communities do not understand the difference. And we know that the Federal Medicare program was constructed—and reconstructed—and administered always with a bias toward acute care. So our experience has shown us that people do not understand this. Lawmakers at the State level do not understand this. It does seem amazing to the public, particularly the elderly public who is taking advantage of the Medicare system, that there is no long-term nursing facility benefit in the Medicare program. The people do not understand why this is true.

If a nursing facility does participate in the Medicare program and if the patient does qualify, then the patient's condition and the nursing facility must mimic Medicare. It must mimic in the patient's condition everything that we associate with the acute care. This is a barrier to our elderly population.

Barrier No. 2 is the requirement that a person seeking Medicare skilled nursing benefits must first have spent 3 days in a hospital. We do recognize that some people think that this requirement serves a gatekeeper function. At the same time, this requirement, we feel, facilitates unnecessary hospital stays.

In 1989, when the Medicare Catastrophic Coverage Act was not in effect as far as the 3-day hospital stay is concerned, we had some statistics. That year, nursing facility admissions did increase by 150,000. However, it is estimated that about 65,100 of all Medicare skilled-nursing facility admissions during this time avoided unnecessary hospital stays. The net result is that the elimination of the 3-day hospital requirement reduced Medicare costs by approximately $250 million during the life of the Medicare Catastrophic Coverage Act.

Barrier No. 3, we feel, is the inadequate reimbursement qualities of Medicare programs in general. It would be difficult to overstate the tremendous positive benefit of the Medicaid program in the State of Mississippi. But Medicaid programs have to be constructed and are constructed within the parameters of cost containment rather than adequate payment for demanded services.

This drive for cost containment, because it is subsidized by the taxpayer, does impose additional barriers to the public. The public goes to the local nursing facility expecting admission of a loved one, and sometimes they don't find it. We call this a barrier. One of the things that grows out of the Medicaid system is the wage disparity between the nursing facility nurse and the hospital nurse. Hospital nurses, because of difference in reimbursement systems, most often get a higher wage scale than the nursing facility nurse.

The staffing problems, unavailability of licensed nurses and physicians, those things have been spoken to already today. But the result is a barrier; that barrier being that the nursing facility may not be able to maintain an increasingly high census of patients requiring heavy care or constant 24-hour supervision. It creates high staff turnover. High stress, low pay, makes the local fast-food restaurant look like a good place to work, or the local factory. And then nursing facilities have more problems and there are more barriers to the public.

The burdensome regulations, paper compliance, seems like it's more important sometimes than the happiness and well-being of the patient.

And then we come to the general atmosphere of uncertainty within the long-term care nursing facility provider system, due to massive congressional changes to the facility system by OBRA 1987, implementing largely—and I would have to say, totally—totally without written regulations and timely guidance from Federal regulatory agencies.

I am not going to come here and offer all these problems and barriers without naming some things that we feel from a State and a national perspective might serve to alleviate some of the barriers. One, we feel, involves a continuum of care. The Nation's long-term care financing system should provide access to the appropriate level of care along the entire continuum so that the patient need and efficient use of resources, not availability of benefits, determines the care setting.

Consumer empowerment: Consumers—the elderly and their families—should have as much as practical to say about the setting and who provides the care. Payment for quality care: Our long term care payment system should encourage and reward quality care.

Encouragement of family support: Public resources should supplement, not supplant, personal and family efforts to provide and pay for long-term care. Right now, it's just all-or-nothing. Medicaid is attempting to stretch itself across the borders of the middle class, not just the poverty patients.

Private and public partnership: The private sector should be encouraged to fulfill the largest possible role in the financing of long term care.

Federal-State roles: There should be a Federal and State partnership of the administration, enforcement, and funding that is designed to eliminate conflicts.

Dedicated funding source: Public long-term funding should be financed through an actuarially sound trust fund that provides both political and fiscal stability.

Simplicity: Our long-term care system should maximize the use of public funds on patient care by seeking administrative simplicity and economy. I think Dr. Hendrix spoke of the complexity of trying to get a patient in a nursing facility these days. And don't forget, the facility, yes, gets discouraged; but don't forget how discouraged the patient feels, and the family. They are the ones who feel so discouraged when they are met with that maze of administrative things that they have to do. That is the barrier.

We feel that the principles I have just named could serve to evaluate both the elements of sweeping reform that some people advocate, and the incremental changes which we feel are more likely to occur, given today's climate of budgetary limitations. We feel that the results, though, of using these suggestions, however, would be the same, and that result would be the minimization of barriers to long-term health care for the elderly.

Thank you.

[The prepared statement of Ms. White appears in the appendix.]

Senator COCHRAN. Thank you very much, Ms. White, for your excellent comments and your perspective on the issue that we are discussing today.

Our final member of this panel is Mr. Clifford Johnson, the administrator of the Northwest Mississippi Regional Medical Center. Cliff.

Mr. JOHNSON. Thank you, Senator Cochran. Welcome to Clarksdale. I would like to thank you for this opportunity to speak today to address the problems of access to health care for the elderly. As you know, I represent the Mississippi Hospital Association, and even though today I will say a lot about our local medical community here in Coahoma County, I would want you to know that the problems and the needs that I address are typical of all of rural hospitals across the State of Mississippi.

I would first like to tell you about the medical community here in Coahoma County. The hospital that we have was opened in 1952 as a 100-bed general acute care hospital. We now operate 194 beds, and just recently we were authorized to convert 20 of our acute

care beds to long-term care beds, and this should help meet the needs that the elderly have.

Our most significant growth, however, has not been in the bed situation but in the expansion of the services that we provide. We have a very highly trained physician staff of 44 doctors, 50 percent of whom are board-certified specialists. We have an employee staff of 550 employees, and our annual budget exceeds $40 million. We offer all major medical and surgical services except for cardiovascular surgery and neurosurgery.

In other words, this hospital is providing care to patients in the seven-county area of the Mississippi Delta with facilities and physician expertise that are commensurate with many of our urban counterparts. We function as a regional referral center, though at the present time we are not recognized as such by HCFA due to our failure to meet some of the case mix indices.

So this morning let us consider our present position as a rural health care provider. On the positive side, in reducing barriers to access, I can report that in this community most physicians treat Medicare patients. Additionally, Medicare recipients are promptly accepted for care at our hospital without regard to race, color, or ability to pay. Our emergency department is staffed 24 hours a day with full-time physician coverage, and our ambulances respond at a moment's notice.

In December, our hospital purchased a six-county home health agency in an effort to provide additional services to the people that we serve. There is a problem with transportation in our community, and the home health agency relieves this situation to some degree in that we take health care to the patients. There are many towns and communities within this six-county area that we serve that are in desperate need of health care, and we feel that this was certain to be an improvement.

Our hospital is also involved in an emergency response program called Life Line. We have just expanded this program, and we will soon have over 125 units in this county. This response center allows the aged or handicapped person to summon help instantly. But the majority of the persons using Life Line are aged individuals.

Further prospects concerning ready access to health care are quite different, however. In my estimation, the real present danger in Clarksdale and Coahoma County and in other rural areas of our State is a complete failure of doctors and hospitals to survive economically by reason of carrying the huge financial losses incurred in caring for the elderly and the indigent. This is a major barrier for health care.

Several factors relative to Medicare reimbursement and HCFA regulations are at the root cause. And if you know me, Senator, you know that, if I get the chance, I am always going to say something about the rural/urban differential in reimbursement. So I would like to talk about that and one other thing for just a minute.

One of the most crippling economic blows to our hospital lies in the inequities of the urban/rural differential. One good example of this that I can cite is the disproportionate share payment system. Now, I have included other examples in my documentation, but I just want to talk about this one right now.

Disproportionate share payments are made to hospitals based o the level of low-income patients treated, which includes many the elderly. Currently, urban and rural hospitals are paid unde different methodologies which heavily favor urbans. Rural hospit payment for disproportionate share is fixed at an add-on rate of percent provided that a minimum level of low-income patients ar treated. Urban hospital payments, on the other hand, are based o the total percentage of low-income patients treated. That is ex plained further in my documentation also.

In our facility, sufficient low-income patients are treated to brin our add-on payment to approximately 22 percent, not 4 percent Yet we only get the 4 percent. If our disproportionate share wer calculated as the urban hospitals are, we would receive ove $1,700,000 annually. But since that is not the case, we must leav over $1,400,000 on the table. I can't begin to tell you, Senator what $1 million means to a hospital such as ours.

Disproportionate share, by its very nature, is a payment systen designed to compensate hospitals treating unusually large number of low-income patients. Why cannot the formula be the same? Such discriminatory practices are putting rural hospitals in an untenable position.

Insofar as Medicare reimbursement to our hospital is concerned the DRG prospective payment system discounts approximately 50 to 60 percent of our charges. And I would remind you again that we are 60 percent Medicare by patient mix.

I have enclosed an exhibit illustrating the fact that if the rural hospital in Clarksdale had been treated equally with the urban hospitals during fiscal year 1991, the medical center would have received an additional $769.35 per discharge, or approximately $2,104,000. And when you add that to the figure above, you have almost $4 million that we could have had if we had been paid on the same level as urban hospitals.

It would appear that there is some sort of Federal squeeze plan under way to make it economically impossible to practice medicine in rural Mississippi and, therefore, shut us down. It is imperative that someone thinks this situation through to the grim consequences that would surely follow if the Government continues its present approach to Medicare reimbursement with differing payment scales all over the country. No business can overcome such duress.

When you couple the disparity in payment between urban and rural areas with the fact that often there is a higher concentration of elderly patients in rural communities, it compounds the problem.

I would like to change and talk about the physician plight for just a minute. The whole cycle of health care begins and ends with doctors. The success of the Medicare program rests in the willingness of physicians to participate in it. We have 44 physicians on our staff, and I am so appreciative of their dedicated efforts on behalf of our patients.

As bad as the hospital's plight is in fighting the inequities of urban/rural reimbursement, I believe the physicians are penalized even more. Physicians here are increasingly questioning if they can afford to see Medicare patients at all. Again, discounts of 50 to 60

percent of charges are commonplace. Physicians have totally lost confidence in our Federally funded programs.

In my documentation I have provided comments from some of our medical staff members which I urge you to read. They have stated their case in alarming terms, and we must not turn a deaf ear.

Physicians point out that even though the Government claims to have figures which in the past have justified the disparity between urban and rural reimbursement schedules, our physicians working in the trenches do not see any financial advantages to practicing in rural areas. More to the point, why should they practice here when one hour to the north, in Memphis, Tennessee, physicians are receiving three times the reimbursement for seeing Medicare patients as Clarksdale physicians?

They tell me that it is their experience that they not only have to pay the same for supplies, personnel, and services, but in many instances are required to pay a higher fee due to Clarksdale's remote distance from major urban service centers.

The only hope that we see for improved reimbursement to physicians in this area is to equalize reimbursement levels between urban and rural providers. However, Federal sources indicate that we will probably see only a reduction in urban reimbursement and the rural rate will be kept at the same level.

By 1995, 13 of our 44 physicians will have achieved or passed the age of 65. That is roughly one-third of our medical staff. Economic constraints are causing many of our most highly qualified physicians to work weekends in various emergency rooms about the area in order to supplement their incomes, a direct result of inadequate Federal reimbursement for services rendered.

I ask you, how are we to recruit physicians for the future under these circumstances? What young doctor is going to choose rural Mississippi when he can hang his shingle anywhere else and be better off financially? Failure to recruit future health care professionals to the rural South is a major threat to access to health care for the elderly and everyone else.

I must mention the need for some sort of transportation system that would provide a means for the elderly and poor, to keep doctors appointments or access hospital services, etc. This has been documented many times before, and we have mentioned it to you before. Yet, we seem no closer to a solution. It certainly is a needful thing in this area.

I also need to comment that I feel that Medicare has made a step in the right direction to begin paying for screening procedures such as mammograms and pap smears. I think that was mentioned earlier. I endorse any efforts to underwrite preventive measures which lead to early detection and diagnosis of cancer and other dreaded diseases. This is certainly a more cost-effective approach and would surely result in a better quality of life for our seniors.

Probably the most complicated and costly medical need for the elderly is the matter of long-term care. Medicare reimbursement is very limited at this time, but clearly the elderly live in fear of how to pay for long-term care. The typical yearly cost, mostly out of pocket, is $20,000 for a nursing home bed. The average stay is 2 years. This is a tough issue with no easy answers.

So where are we? We know the older population is multiplyin rapidly. By the end of this century there will be some 31 millio people in the 65-and-over category. By the time the entire baby boom generation retires, there will be some 55 million American over 65, comprising about 18 percent of the population. We kno the expanded years are attributable to advances in medical tech nology which have come to the fore since Medicare was enacted i 1965, innovations like antibiotics, hemodialysis, pacemakers, ca diac bypasses, hip replacements, and so on.

Yes, we are aware of the graying of America. Yet, in recen years, the Nation's birth rate has sharply declined. We know ther are millions of homeless Americans who are not in the social secu rity system. We know that thousands of others are unemployed o otherwise impaired and not part of productive society.

What I am saying is that there are fewer people in the workforc to pick up the tab for the biggest Medicare generation yet experi enced in this country. How do we pay for health care for the elderly in generations to come? Who has the responsibility to determin when the health care provided is adequate or appropriate?

Congress made a promise to older Americans in 1965 when it ini tiated the Medicare program. The promise, in part, was that the best possible physical and mental health which science could make available without regard to economic status would be extended to them. This promise has certainly been kept. But you must realize that it is the physician and hospital providers who have kept the promise by bearing the brunt of uncompensated care. The Congress of 1965 could not possibly have foreseen 1991 costs. As a hospital administrator, I am beginning to wonder if this promise can continue to be kept.

It has been said that, "Without a vision, the people perish." Senator Cochran, I ask you, what is America's vision? I respectfully suggest to you that high on the national agenda must be the Nation's health care delivery system, particularly as it affects rural physicians and hospitals. Unless Congress confronts this issue now with some tough, objective actions to equalize Medicare reimbursement to physicians and health care providers, there will be a health care crisis in this country such as never before experienced in the history of this Nation. It is my hope that this will not happen.

I want to thank you for your interest in health care, Senator, not only for the elderly but in other areas that we have discussed before. Thank you so much.

[The prepared statement of Mr. Johnson appears in the appendix.]

Senator COCHRAN. Thank you very much, Clifford Johnson, for your testimony, very compelling testimony. I also appreciate your including as a part of your statement to the committee the information that you have supplemented your statement with: the statistics, and also the letters. When I arrived in Clarksdale last night, I had this material, and I read the enclosures that you included, including letters from physicians and others who have had experience in dealing with the problems that you have mentioned and highlighted, and it is very impressive.

The article that you included in here I thought was particularly appropriate, "Healing the Delta," by Frank Clancy. I read that as well.

All of this indicates to me, not only your testimony and these enclosures that I am mentioning, but the testimony of other witnesses, too, that we are at a point of real crisis. And I think it's at the point where immediate action is required, if we are not going to get into even more serious situation. The older our population gets, the more demands there are on the system, the more expensive the cost becomes, and the higher the barriers get to reasonably priced health care products and services.

One of our witnesses mentioned that the costs of medications continues to go up, and are out of reach. Some people just have to make a decision whether they're going to pay the rent or pay the light bill or pay the bill for prescriptions. A lot of times, the prescriptions bill gets kicked out, or the prescription is something that the patient determines just has to be put aside until an opportunity can be found to deal with it.

So these are very real problems, and this panel has done a lot, I think, to highlight some of the specifics and day-to-day challenges that health care providers are facing.

I don't know that I have a magic answer, but I do want to thank you for helping to focus our attention on some of these specifics. In the case of Ms. White's testimony, for example, she raised the problem of no reimbursement whatsoever for long-term care as compared with at least a program of Medicare reimbursement for acute care, and whether or not that is something that we can continue to ignore.

The testimony of Dr. Curtis I thought was especially helpful in trying to identify some specific things that we could consider doing. Specialized geriatric training is very definitely needed.

With respect to reforming Federal policies to permit reimbursement to providers of gerontological specialty services, as I understand your testimony, there is no reimbursement now for such services. If a person is a provider of specialized services of that kind, are they categorically disallowed reimbursement? I thought we did have some home health care services provided that were reimbursable.

Dr. CURTIS. Yes, Senator, you are correct, there are some home health care services that are reimbursable. Those are directly reimbursable to nurses. The person, the specialist in gerontology, is not considered within that reimbursement policy. So what he or she has been doing is filing for reimbursement as either consultant to the home health care agency, or filing under the name of a nurse that is providing care of the home health care agency, or the home health care agency has been swallowing the expense for his or her services.

Senator COCHRAN. You also mentioned respite care, and maybe daycare centers and vacation opportunities for those who were providing care, as an alternative to institutional care. We have talked about that some at earlier hearings, and that is a situation that I think does need some more attention. It doesn't seem that under the Older Americans Act or other Federal programs there is enough of that kind of assistance. I know there are some home

services that are provided, but they are very limited and really don't meet the needs of a large number of people. Those who are beneficiaries of that kind of service genuinely appreciate it.

One of our guests here this morning was just remarking to me before the hearing started about someone in this community whose family member had had a serious physical impairment, and the woman who was his spouse was trying to take care of him and just couldn't do it. But with some added assistance from people who come by the home on a regular basis and help her with just household chores and the hygiene needs of the ill family member, that means a lot and it keeps them from having to put him in a long-term care facility.

What do we do about that? Do you have any special thoughts about how we do that, how we deal with that as a practical matter?

Dr. CURTIS. Deal with the outreach programs?

Senator COCHRAN. Yes, the outreach programs and providing these respite care services.

Dr. CURTIS. Well, my suggestion is to look at the acute care centers and the nursing home facilities and in some way assist them in providing finances to support those respite beds for the individual who has the illness.

Or another thought I have is that I think a university setting would be a wonderful place for daycare centers because it's interdisciplinary and the elder could be stimulated by input from all of the departments and divisions within the university setting. But right now there is not really any funding in the form of grants that are an easy access to help with that.

The outreach programs themselves, the one that we have in Columbus, Senator, is so wonderful. But when they started it, it was like scratching the surface. They have waiting lists in five counties begging for more help, and they are just tapped out; they're doing the best they can.

But if there were some mechanism that we could use to encourage and increase those outreach programs for some of these rural elders who are homebound, it would be wonderful.

I am sorry I don't have a real solution. I wish I did.

Senator COCHRAN. Dr. Howell, you wanted to make a comment?

Dr. HOWELL. Senator, back in 1990, there was a report to the State Medicaid Commission called the Ladd Report. And in this a survey was done for the Medicaid Commission addressing long-term care. I really did not get into this in my paper. But essentially, this report felt that nursing homes held a lot of patients that did not need their complex care, and it recommended that prescreening exams be set up and common assessment tools be used to determine which patients could be cared for outside of a nursing home. A nursing home is quite expensive in comparison to a number of the other sources of alternative care that could be provided.

In Mississippi, in 1989, I believe about 97 percent of Medicaid funds for long-term care went to nursing homes.

The State Medical Association supports the idea of the development of adult day centers, of adult foster homes, and of transportation, meal, and chore services to elderly Mississippians.

Senator COCHRAN. One thing that you mentioned, and so did Clifford Johnson, was the problem with the Medicare reimbursement differential; the fact that we are treated differently—which is implied in the term itself—from those in other areas of the country because we are not as large, we don't have the population base. And according to Clifford Johnson's statement, there was another phrase that he used, "case mix indices were not sufficient to meet the requirements of the Health Care Financing Administration."

My understanding was that we passed legislation that will require equalization of physician reimbursements by 1995 and this is to be phased in and completed by that date. But I understand from your testimony that you are not impressed by that. Did you fear the way it's going to be equalized is that the urban physicians are simply going to be brought down to the level of reimbursement of those in our area here, for example? Is that based on something you have gotten pretty firmly from the regulators or some other source?

Mr. JOHNSON. That is just what our physicians are telling us. I don't have any hard data right now for that.

Senator COCHRAN. Do you have any basis for fearing that other than just distrust of Government?

Dr. HOWELL. Basically, I know that there are a lot of proposals concerning payment systems. But I do not have any hard data right before me.

Senator COCHRAN. OK. Well, one thing that I have been convinced of is that that was terribly unfair. And a few years ago, I know I joined with other Senators from States that were similarly affected in cosponsoring legislation which was enacted to correct this. Although it's not an immediate equalization, it does require equalization over a period of time. I want to assure you that I am going to continue to monitor that.

What also disturbs me, though, and I think Clifford Johnson's testimony is very clearly illustrative of the problem, is that this regional medical center here, for example, is treated differently. Even though it treats patients from a multicounty region, it has a large staff and provides sophisticated services of almost every kind that you can get in any big-city environment, except I think you mentioned neurosurgery and cardiovascular surgery. So, for all practical purposes it's an urban facility.

My point is that it is indistinguishable in terms of its mission, its functions, its services, and the quality of the physicians and the other personnel and staff who work there. It's the same as an urban facility, so there ought not to be, in my judgment, any difference in the level of reimbursement. Supplies cost the same, the expenses are the same. In some cases, I think you said, they're higher because of transportation costs, getting things here.

So I don't know what else to tell you except we need to accelerate the rate of equalization or, if that is separate from the physician reimbursement legislation that has already been enacted, then I think we ought to try to get the same kind of legislation enacted that relates to hospitals and regional facilities like here at Clarksdale.

So we will work on that.

Mr. JOHNSON. Senator, can I say something?

Senator COCHRAN. Yes, sir.

Mr. JOHNSON. In talking about the case mix indices, that is based on the acuity level of the patient or the severity of illness and that is how the case mix is figured. That is how they determine whether we would be a rural referral center or not. Now, a hospital, a rural hospital that begins to do heart surgery or that begins to do neurosurgery, will get their case mix leveled up much higher, and they then get to become a rural referral center. We still serve all the people and we serve as a rural referral center, and yet we don't do neurosurgery and we don't do cardiovascular surgery. Those are the things that get the case mix up or get the acuity level up.

Senator COCHRAN. I see.

Mr. JOHNSON. But like you say, we are still doing the same work as an urban center would do.

Senator COCHRAN. Well, I am hoping that we can use this testimony and these materials that we have available to us now as a way to persuade the Congress and the Administration to make changes that will make it more fair and equitable for those in areas of the country like Clarksdale, MS.

I want to thank you for being here. We are going to take a little break now of about 5 minutes and stretch your legs and do whatever you have to do, maybe get a cup of coffee. There is coffee in an adjacent room here. We appreciate it very much.

Then we will reconvene in about 5 minutes with our final panel.

[Recess.]

Senator COCHRAN. Well, if we are all set, we can reconvene the hearing for our third panel of witnesses. Our third panel of witnesses today includes: Helen Wetherbee, who is director of the division of Medicaid in the Office of the Governor; George Holland, who is the regional director of the Health Care Financing Administration, which oversees the Medicare program as well as Medicaid; Bill Shakelford, who is public affairs director for Blue Cross/Blue Shield of Mississippi. This is, of course, a major Medicare contractor providing day-to-day payment and customer service to Medicare beneficiaries.

We appreciate very much this panel being here and helping us to discuss and think about ways to improve access to health care services and products in Mississippi in particular, but, as far as older Americans are concerned, throughout the country.

Let's start with Ms. Wetherbee, and you may proceed. Thank you for being here.

STATEMENTS OF HELEN WETHERBEE, EXECUTIVE DIRECTOR, MISSISSIPPI DIVISION OF MEDICAID; BILL SHAKELFORD, DIRECTOR OF PUBLIC AFFAIRS, BLUE CROSS/BLUE SHIELD OF MISSISSIPPI; AND GEORGE R. HOLLAND, REGIONAL ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Ms. WETHERBEE. Thank you, Senator Cochran. I feel that you have already listened to a lot of numbers, so I will keep them to a minimum. But of the 280,000 elderly Mississippians over the age of 65, 95,000 are living below the national poverty level. This is approximately 11 percent, and it's a very high proportion of impoverished elderly. Other States have levels more like 5 or 6 percent.

Of the 95,000 living below the poverty level, 75,000 are now receiving some form of medical assistance through the Medicaid program. This ranges from Medicaid's direct reimbursement for medical services to Medicaid's picking up the coinsurance and copayments for Medicare enrollment.

Mississippi had already initiated phased-in coverage of the elderly up to 100 percent of poverty before it became mandatory under OBRA 90. In an effort to do that, the State had expanded its eligibility staff to 100 workers and the number of regional offices to 24, in an effort to facilitate enrollment of the elderly and the disabled.

We anticipate that at the end of this calendar year approximately 85,000 elderly will be served through the Medicaid program, representing nearly 90 percent of the total elderly Mississippians living at or below the poverty level.

It has already been mentioned, a primary barrier to care in the Medicaid program is the low level of physician participation. I believe Dr. Howell has already addressed this issue. I should add, however, that last year a survey was conducted by my predecessor directing the Medicaid program to determine the reasons for physician nonparticipation in the program. The most frequently cited problem was inadequate reimbursement.

This study, however, was followed by another survey at the national level, which revealed that in Mississippi, as in other States, reimbursement is not the primary motivator for participation, but the real problems lie in physicians' perception of patient abuse of the health care system and the perception that Medicaid patients are more difficult to manage and more likely to litigate.

These, I think, are the true barriers to physician participation in Mississippi.

With respect to reimbursement rates, I should mention that, in our State, legislative action is required for any changes in reimbursement, and this year, because of the State's fiscal crisis, no increase was authorized.

A second barrier to provision of care in the Medicaid program is transportation, as Dr. Dorsey has already mentioned. We are required to provide transportation for Medicaid recipients in Mississippi, but I can only be candid and admit that in many counties this is not a program that is working well. We are now working with our State human service agencies and our State transportation agency in an effort to develop new models to address this problem.

Some of our attempts to resolve problems are frustrated by the third barrier I would like to mention, and that is the regulatory environment at both the State and Federal level. At the State level, not only is the program entirely dictated by legislative action, but with our current program the division of Medicaid has no control over admissions, for example, to nursing facilities. The same is true for home health services and for the home and community-based waiver program that I will mention later.

We have a need for additional nursing home beds in Mississippi, which is currently restricted by a legislative moratorium. Under our current framework we have no way of assuring that the severely impaired, whether physically or mentally, are not rejected

by nursing facilities in preference for recipients requiring less in tensive care.

At the Federal level, Mississippi has hardly been able to fund th mandated expansions of the last several years. These include nc only the nursing home revisions of 1987 and the expansion of elig bility to the elderly up to 100 percent of poverty, but a much great er expansion of coverage and services to pregnant women and chil dren. In spite of the Federal-State match of 4 Federal dollars to State dollar, there are not sufficient funds in Mississippi to main tain these services for the very high proportion of Mississippian living at or below the poverty threshold.

I should mention as well that it is because of the 4-to-1 matcl that Mississippi has no choice but to comply with the Federal man dates because we are so desperately dependent on the Federal dol lar.

The forced expansions have led to increases in the program cost of 24 percent in fiscal years 1990 and 1991 and 49 percent for fisca year 1992. Our budget for fiscal year 1992 is now $1.1 billion. Tha is the first State program to break the billion-dollar barrier, an(I would suggest this figure should be compared to the $591 millio budget we had in 1990.

In the absence of sufficient State funds or perhaps to illustrat the insufficiency of State funds, the legislature has enacted a pro vider assessment program to generate State matching dollars. I addition to that, the disproportionate share hospitals are expecte to donate some $40 million, all of which are absolutely necessar if our program is to be funded next year.

My point is that as an alternative to this struggle to fund a forced program, Mississippi is among the States supporting th proposal that Federal legislation afford the States some period o time, such as 2 years, in which to meet the latest mandates. Les pressure on the State budget would permit us to assume some ini tiative in developing programs and services particularly suited t our State.

I should emphasize that Mississippi does not oppose the expan sion. In fact, we welcome it. But we merely want the discretion o the latitude to develop a program tailored to Mississippi's needs. don't think this is the forum to dwell on the drug formulary an rebate provisions, but that is an example of a Federal mandat that will save money on a nationwide basis but which will cost Mis sissippi, in spite of the rebates, a net loss of approximately $12 mil lion.

In searching for solutions, it is important to note that nursing home residents constitute 4 percent of the total Medicaid popu lation, while the cost of their care consumes 30 percent of the medi cal services budget. In January of this year, as I mentioned, more than 75,000 Medicaid recipients were 65 years of age or older. With respect to all Medicaid services, the cost per elderly client is ap proximately $3,200. Of those elderly recipients residing in nursing homes, however, the average cost is $7,577.

While there was a 23-percent increase over the last year in the number of elderly recipients, there was a 43 percent increase in the number of elderly recipients residing in nursing homes. Clearly less costly alternatives to nursing home care are needed.

Mississippi does have a small home- and community-based services program. For 500 recipients, a special battery of services offers an alternative to institutionalization. The services include case management, expanded home health, homemakers, respite care, and adult care services. So, for 500 Mississippians, some of the suggestions that have been made earlier are available. This is an optional program. The annual cost is $2,000 per recipient. Remember that the annual cost for long-term care for our Medicaid recipients is over $7,500. We do feel that this program should be expanded, but it is optional. And the legislature this year has refused to fund any optional expansions because of the cost of implementing the Federally mandated expansions, particularly OBRA 90.

We also hope to address other problems of access through the development of managed care programs for the frail elderly. The legislature has authorized two pilot programs which we are presently in the process of developing. We hope to establish a medical home for elderly clients to facilitate access to needed services and prevent duplication or overlapping, most especially with respect to medication.

Finally, there are some fundamental questions which underlie the role of the Medicaid program in meeting the health care needs of the elderly. Remembering that at its inception Medicaid provided limited medical assistance to limited categories of low-income people, the elderly have been relatively well served by the program. In recent years, however, Federal priority in the Medicaid program has been placed upon pregnant women and children, now served in some instances up to 200 percent of poverty, and provided all medically necessary services without the restrictions that have been used in the past to control costs.

Currently, 15 percent of Medicaid recipients in this State are over 65, while the cost of this service consumes nearly 40 percent of the program budget. Some health analysts now question whether Medicaid should serve the elderly at all or whether their costs should be shifted to Medicare. The lack of Medicare coverage of certain services arguably drives up the cost to Medicaid. There are also questions whether nursing homes may properly be considered medical services and whether their exorbitant costs should be paid by the Medicaid program.

In conclusion, the Medicaid program is playing a major role in providing traditional medical services to the elderly with incomes below the poverty threshold. It appears that the reimbursement for these recipients will total more than $250 million this year. The money is being spent primarily on long-term care and inpatient hospitalization, and the costs are overwhelming.

However funded, there is a definite need for alternatives such as I have outlined in our home- and community-based services program.

That concludes my remarks. I would just like to mention that I do have a copy of the Ladd Report that Dr. Howell mentioned earlier, and I will leave that with Mr. Thigpen.

I wanted to minimize my comments about the drug program, but thank you for your work with Senator Bentsen in the colloquy on the floor, and I would just mention that Mr. Thigpen was ex-

tremely helpful to us and cooperative in getting all that arrange
Thank you.

[The prepared statement of Ms. Wetherbee appears in the appe
dix.]

Senator COCHRAN. Well, we appreciate your being here, M
Wetherbee. I am glad you have a copy of the Ladd Report. We w
make that a part of record of the hearing so we will have that
our transcript of these proceedings. We appreciate your comment
too, on our assistance in the Senate, working with Senator Bents
to get some clarifying understanding to be helpful to the State.

[The Ladd Report appears in the appendix.]

Senator COCHRAN. Mr. Holland.

Mr. HOLLAND. Thank you. Good morning, Mr. Chairman.

Senator COCHRAN. Welcome.

Mr. HOLLAND. I am pleased to be here today to describe th
Health Care Financing Administration's efforts to ensure that Me
icare beneficiaries have access to necessary health care. The elderl
are a unique group when discussing access to health care service
Compared to other age groups, individuals who are 65 years of ag
or over are relatively well insured. More than 95 percent of thes
individuals are covered by Medicare and 70 percent have supple
mental health insurance coverage through medigap policies.

HCFA supports several initiatives to improve the ability of th
Medicare elderly to get the care they need. We seek to accomplis
this improvement in access by providing positive incentives to pro
vide care only when necessary and at the appropriate level.

Now, the physician payment reform enacted in 1989 is intende
to make Medicare physician reimbursements more equitable acros
services. Under the new physician fee schedule which will be im
plemented beginning January 1 of 1992, payments to primary car
physicians will increase relative to specialists. This provides an in
centive to provide basic primary care and should improve access t
those services.

In order to improve access to physician services in medically un
derserved areas, Medicare pays physicians in these areas a bonus
of 10 percent to provide services to Medicare beneficiaries. Mis
sissippi has 88 areas designated as medically underserved. There
are approximately 517 physicians in Mississippi who are eligible
for this bonus.

Beneficiaries are also encouraged to save money on physician
services by receiving their care from Medicare-participating physi
cians. These physicians accept Medicare-approved charges as the
total payment for services. Nonparticipating physicians are paid a
reduced amount of the improved payment.

Physician participation rates have increased every year since the
inception of the program. The national participation rate in 1990
was 44 percent. Mississippi had a slightly smaller physician par
ticipation rate of 38 percent in 1990. This was a 13 percent in
crease from 1989, and we expect to see an additional increase this
year when rates are available later this month.

The number of physician bills paid under assignment—that is,
acceptance of the Medicare-approved amount as payment in full—
is at an all-time high. In fiscal year 1990, 81 percent of physician

bills were paid under assignment, relieving beneficiaries from the financial burden of balance billing.

We have implemented several provisions to assure hospital care is available in rural areas. Since 1988, rural hospitals have received larger Medicare payment increases than urban hospitals. Nevertheless, these hospitals generally are more financially vulnerable than their urban counterparts, due to declining occupancy and other economic factors. To protect the financial stability of rural hospitals, HCFA is phasing in a single national payment amount to replace the separate urban and rural Medicare standard amounts, which is to be completed by 1995.

Medicare also maintains its special treatment of rural referral centers and sole community hospitals. These hospitals receive higher payment to protect their unique status as providers in their communities. In Mississippi we have 11 hospitals designated as rural referral centers, while two are sole community hospitals.

HCFA is also working to assist rural communities in reconfiguring their health care delivery systems. We are in the process of implementing the OBRA 89 provisions to designate certain rural hospitals as essential-access community hospitals and rural primary care hospitals. This designation will offer assistance to States in assuring the availability of emergency treatment services in rural areas where it is not financially feasible to maintain a full-service hospital. Applications were sent out at the end of January. We expect to have applications returned by May 1 and to make awards by September.

In addition, we have awarded the second round of rural health transition grants that will help small rural hospitals modify their services to adjust to market condition and community health needs. A total of 394 transition grants and $25.1 million have been awarded to date. Mississippi has received nine grants worth over $575,000.

HCFA has recently published proposed regulations for folding capital payments into the prospective payment systems for hospitals. By law, Medicare is required to do this beginning October 1 of 1991. When fully implemented, a capital PPS will provide hospitals with a fixed amount for each Medicare admission and will establish a single national rate regardless of whether a hospital is rural or urban. A capital PPS will encourage hospitals to make prudent capital decisions.

Many people are concerned about the impact of the proposed regulations on rural hospitals. Establishing a Federal rate based on the average capital spending for all hospitals results in the low-cost hospitals receiving a higher capital PPS payment than under the current cost system. Because the majority of rural hospitals have capital costs well below the national average, they are likely to fare well under the proposed change as long as they continue to make prudent capital investments.

To aid hospitals with capital costs above the national average, the regulation includes an exception policy to provide additional payment for costs in excess of 150 percent of the payment. There is also a generous exception policy for rural sole community hospitals.

We continue to seek better care and better value for our hea dollars in the Medicare program. Coordinating care conser scarce health resources by providing only necessary care, ther containing health costs.

Currently, Medicare has about 1.25 million beneficiaries enrol in the risk health maintenance organizations. Although no M sissippi Medicare beneficiaries are enrolled in risk HMO's, we this as a potential area of expansion in the future.

Coordinated care plans such as HMO's and competitive medi plans provide quality care at an affordable price. Medicare be ficiaries who join coordinated care plans usually have less out pocket costs than fee-for-service because HMO's and CMP's g erally have smaller coinsurance payments which are more pred able.

Now, the President's budget includes a $40 million coordina care initiative for fiscal year 1992 and $1.4 billion over 5 yea The initiative is designed to strengthen the existing Medicare ordinated program and expand options available to the be ficiaries.

We are also looking at the larger question of access to hea care and long-term care. The importance of this issue is evidenc by the number of groups established to address these problems a recommend solutions. And of course that was discussed this mo ing.

The U.S. Bipartisan Commission on Comprehensive Health Ca the Pepper Commission, has already issued its report of findin and the Social Security Advisory Council is also expected to co forth with its recommendations. The National Governors' Assoc tion has designated health care reform as its No. 1 priority for t year and is conducting a study that is expected to be completed August of 1991.

In addition, a special departmental task force is also charg with exploring solutions to problems of health care access, equi and cost. HCFA Administrator Gail Wilensky serves as vice ch of the task force. The mission of the task force includes a thorou analysis of long-term care issues and options for financing init tives.

In conclusion, Mr. Chairman, HCFA supports many progra which are intended to improve beneficiary access to physician a hospital services, maintain services in rural areas, and expand a cess to coordinated care. We also continue to seek comprehensi solutions to the problem of access to care for the elderly.

Thank you. I am happy to answer questions as they arise.

[The prepared statement of Mr. Holland appears in the appe dix.]

Senator COCHRAN. Thank you very much, Mr. Holland for yo expert statement and for being here. As a regional administrat we know you are busy and have a lot of things under your jurisd tion. We appreciate your coming over here and helping us as y have.

Mr. Bill Shakelford is our next witness.

Bill, welcome to the hearing.

Mr. SHAKELFORD. Thank you, Senator. It is a pleasure for us be here and to participate in this panel.

Three things come to mind almost immediately in addressing the subject of access to health care for the elderly: one, the availability of health care services; two, financing, or who is going to pay and how will it be paid for; and, three, information and education; that is, teaching our people how to access the system, or nonsystem, as some prefer to call it, to get the benefits to which they are entitled through various programs.

I would like to give you a little perspective as one private insurer. The need for Medicare supplement is very evident. The out-of-pocket costs since the advent of Medicare in 1966 has risen from about 12.3 percent of income to about 20 percent of income today. What about the size of the market for this age group? There are about 345,000 people over 65 in Mississippi.

Two things are happening: One, health care costs continue to escalate at a brisk rate; and, two, the over-65 population is growing. In the next 30 years, it is estimated that the population over 65 is expected to increase by 50 percent and the population over 85 will triple.

These trends have convinced us that long-term care and the acute care stage must be a priority of Blue Cross and Blue Shield of Mississippi and, I am sure, other companies too. We are engaged in-house in a comprehensive study to assess our current position in the market and to look to the future.

A word about Medicare supplements. There are a number of private carriers in Mississippi that offer Medicare supplements. The leaders are the AARP, through the Prudential Insurance Company, and Blue Cross and Blue Shield of Mississippi. We estimate that of about 272,000 of nonMedicaid-eligible who are Medicare eligible, about 132,000 have some form of private insurance. Blue Cross and Blue Shield insures about 31 percent of this number. Nationally, about 70 percent of Medicare-eligibles have some form of coverage under a Medicare supplement. In Mississippi we estimate that that number is about 50 percent.

Blue Cross and Blue Shield of Mississippi has a range of Medicare supplements which are regulated by the State Department of Insurance, and financially these products are performing poorly. We have sustained a loss ratio of about 94 percent, and this is due primarily to prescription drugs and inadequate rate relief which has been granted by the insurance department.

Perhaps no subject is more important in the minds of our elderly than long-term care. Who pays for it now? Medicare pays for a part of it, but only for acute conditions. Personal incomes and savings pay for part of it. Medicaid pays for a good part of it, but is available only if the person spends down his or her assets to a specified level. And the fourth payer is private insurance.

Private long-term care insurance is undergoing a dramatic change. Currently, as estimated by the American Academy of Actuaries, about $50 billion is being spent annually on long-term care in the United States, and they predict that this will grow to $225 billion by the year 2000.

Insurance in this area is growing rapidly. In 1986 there were about 130,000 policies for long-term care protection sold. In 1990, about 1.15 million policies were sold. Blue Cross and Blue Shield

of Mississippi is not currently in this market, but is developing product which will be offered in Mississippi in 1991.

The National Association of Insurance Commissioners has established long-term care standards which protect the consumer and will allow this market to grow. The need for standards is evident. There is also a need for continuing education about coverage available and information on how to access the system of health care.

The AARP has taken a leadership role in this area, and they are to be commended for this.

This year we are developing a program dedicated to the elderly subscribers age 65 and over which will extend beyond our service center in Jackson and to other communities in Mississippi. In addition, we have an obligation to work with members of the medical professions, the hospitals, the nursing homes, and Government agencies to improve coverage, to control the costs, and to provide easier access to the available health care services.

We appreciate the opportunity of testifying.

[The prepared statement of Mr. Shakelford appears in the appendix.]

Senator COCHRAN. Thank you very much, Bill Shakelford, for your assistance with this hearing and the perspective that you bring to our discussion today.

In connection with something that Ms. Wetherbee said about the managed care pilot program; the legislature, as I understand it, authorized a pilot program and there is one other as well. Should there be any tax code incentives or other incentives for businesses and individuals to purchase insurance that would provide a managed care program? Is that a feasible thing to do, Mr. Shakelford, or are there any policies of that kind?

Mr. SHAKELFORD. We think that that is an area in which the Government could move to give incentives, especially in the area of long-term care. For example, you could have certain carriers, or all carriers certified that meet standards, and the cost of that coverage paid by the individual could be a tax credit, something of that nature. We think that is an area that the Government could move in.

Senator COCHRAN. I wonder, Ms. Wetherbee, have you had any opportunity to assess the efficacy of expanding the programs that you have started? Are these so new that you really haven't had a chance to look at the effects of them at the State level?

Ms. WETHERBEE. The managed care has not even been implemented yet. So I can't give you any experience on that.

The home- and community-based services program has been going for several years. We need legislative authorization to expand it statewide.

Senator COCHRAN. Well, how do you choose the individuals who qualify and are eligible for the pilot program benefits? Is it on a regional basis, a certain county or town?

Ms. WETHERBEE. The home- and community-based services program is operating in four sites in Mississippi, and admissions to it, if you will, are determined by the Council on Aging, with whom we are working. They are the agency that actually enrolls these individuals. Our only criterion is that they be Medicaid-eligible.

Senator COCHRAN. There has been discussion already today about some of the reimbursement issues, the providers who are either not eligible for reimbursement under current rules or laws, the disparity between the level of reimbursement that is available between rural areas and urban areas.

Mr. Holland, you touched on the fact that there is a phased-in effort to equalize those reimbursements for providers under the 1989 legislative change that was put in place.

Let me ask you this: There is some suspicion that you are going to just reduce the reimbursement available to urban areas and not really increase the rural or small-town providers. What is your reaction to that? Is that what you are up to?

Mr. HOLLAND. Definitely not. Although if that happens—no, we are not doing that. But it will be a 5-year phase-in plan, and I doubt very much if that would happen in the process. It's supposed to come out equal.

Now, Mr. Johnson's statement, which I was listening intently to, was right on the money in many aspects on that case mix discussion that he had. We briefly chatted here. It is a problem. Essentially with the case mix index, we are raising that index based on difficult cases, such as neurosurgery, heart, this type of thing. And his position is that, by this action, which denies him from being classified a rural referral center, we are forcing him into doing those procedures. And his comment was, "Why should you do those procedures when they're not necessary?" And that is a difficult area to deal with. That is the case mix situation that we have been struggling with for a number of years.

Senator COCHRAN. Well, I don't know that we can ever have a perfect world of Federal reimbursement procedures and guidelines and rules, but it seems to me that the small towns and rural areas are getting the short end of this. We've got to address that problem and keep working on it.

Do you have any suggestions, Mr. Holland, for ways that we might consider addressing that as we go through this next session of Congress? We are working on some health care issues. It may very well be that we will get a vehicle coming through the Senate or the House that will give us a chance to make some changes. Do you have any thoughts on that?

Mr. HOLLAND. Well, of course, we are heavily involved in physician payment reform. But I think on that all the legislation is in place, and we are quite excited. I think we are going to see some good results from it.

Senator COCHRAN. This is the value assessment?

Mr. HOLLAND. Right.

Senator COCHRAN. None of the physicians I have talked to like it, though.

Mr. HOLLAND. You said they like it or don't like it?

Senator COCHRAN. I said none of them likes it, none that I have talked to.

Mr. HOLLAND. The AMA likes it.

Senator COCHRAN. Well, some of them don't like it, the ones that are going to end up getting less.

Mr. HOLLAND. Your primary docs will like it.

Senator COCHRAN. Don't like it?

Mr. HOLLAND. No; your primary doctors will like it. I t frankly it will help out a lot of the doctors in rural areas.

Senator COCHRAN. Urologists. I have heard from some urolog They don't like it at all.

Mr. HOLLAND. They would not like it. But as you said, the w field is complex, and we just have a difficult time leveling where everyone likes the process. But that will be a big one.

Senator COCHRAN. What is the status of that? Are you g through a process of implementing some regulations or guideli Where are we?

Mr. HOLLAND. Regulations are coming out. The next big one be coming out in about 2 weeks, and that is going to lay out fee schedules. And you are going to hear a great deal of acti across the country when the actual fees get out.

Then after that, we have to move in with our contractors and up the systems, the processes, train the doctors, and go live Ja ary 1. It's the biggest change in Medicare since the program v enacted, and it's a big one. We are very busy on that. It is go to cause a lot of changes.

The other thing I have heard, and this is a problem, is how you get persons to help other persons in custodial homes or otl situations where we don't reimburse. The one idea I have heard pressed is a bank, where a volunteer, or a series of volunteers together and, say that one person gets sick and comes out of hospital, another person that is well goes over and spends so ma hours with that person, and they bank the time. And when th person gets sick, they draw down from the bank. That seems to working well as a pilot in some regions. In that way, it's accou ability, if I know I will spend 20 hours with Mrs. Jones, I will p 20 hours in the bank, and if I get sick, a well person that is al in the bank would assist me. That seems to work out in some pil areas.

But you're right, it's extremely difficult to provide that custodi care for persons without going after Helen Wetherbee's money fro Medicaid.

Senator COCHRAN. There is one area I don't know whether the is an answer to that we can come up with today, but we certain need to work on it. That is the situation where you're not Medica eligible, your income is at a certain level or your assets are a ce tain level and you're just not eligible.

Is there anything at the State level that we are considering try to deal with that problem, or is there any kind of Governme action that you see, Ms. Wetherbee, that is available to us?

Ms. WETHERBEE. In the last session, there was some initiative i the Senate to take advantage of some Federal provisions tha would have permitted the Medicaid program to purchase insuranc premiums for working families up to 200 percent of poverty. didn't succeed this year, but I suspect we will see that again. Tha is a real problem, but I think now primarily these people are bein served at hospitals such as Dr. Johnson's without compensation, o they are being treated at the Health Department.

Senator COCHRAN. Mr. Shakelford, is this an area where the pri vate sector is going to have to come in and take up the slack an do a better job, maybe, of selling people on the notion of buying in

surance to help protect themselves against risks of this kind? Is there any answer from the private sector?

Mr. SHAKELFORD. We don't have an answer, I don't think. One of our problems is that health care costs escalate so fast that our rates have difficulty keeping up with them. Our rates are too high for the public to buy the coverage, in many cases. And it sort of feeds on itself. As long as we have this escalation in health care costs, it will be reflected in our rates. So we don't have any prospect for relief in that area except in the area of trying to work with physicians through programs that will encourage the control of fees charged and this sort of thing, which is a very difficult area to operate in.

Senator COCHRAN. There is one question that I had, and that was about medigap policies. Some of these very aggressive salesmen come in, and I am not talking about you or your company, but some of these folks are pretty aggressive and even unscrupulous and take advantage of older folks. They say we're going to sell you something you've got to have, and for the laughingly low price of a few hundred dollars, you can protect yourself from this gap between what is paid for by the Government reimbursement programs and what isn't.

What is being done, if anything, Mr. Holland, in terms of trying to identify regulations or rules that would protect the elderly from being duped or fleeced by some of these unscrupulous types?

Mr. HOLLAND. We have a section in our beneficiaries services branch that deals with AARP and other councils, senior councils around the region. And they do a lot of work in this area. The other thing, frankly, when we get these calls, we just turn them right over to the inspector general immediately. I think they do more in that area than we really do on the carriers.

Mr. SHAKELFORD. May I comment?

Senator COCHRAN. Mr. Shakelford.

Mr. SHAKELFORD. There is some Federal legislation which seeks to standardize the medigap programs. And in order to get certified as a good guy, so to speak, you have to meet these standards. This is enforced by the various State commissioners of insurance. I think this has been helpful.

You have raised a very good point. There are a lot of unscrupulous salesmen in this country, and they spend a lot of time with the elderly who may be easily confused about health insurance. They encourage duplication of coverage. We have found cases where some people have had six and seven medigap endorsements, which they do not need because all of them cover essentially the same thing, and that is what Medicare does not cover. So a lot of people that are in this age group are overinsured, there's no question about that, and we think that that is a very bad situation.

Senator COCHRAN. The point that I think some of you have made here is the importance of preventive steps to take to try to keep people healthy. This is the emphasis right now of Dr. Louis Sullivan, who is Secretary of Health and Human Services. He is doing such a good job, I think, of promoting and attracting attention to the fact that one way to avoid the expense of illness is to stay well and watch what you eat, pay attention to other habits, including

smoking and other things that can be very damaging to individu health.

I think we are going to see some positive results from that. W may already have been seeing some changes in terms of overal costs that individuals are having to confront.

Are there any programs at the State level, I was curious, to carr out that kind of effort? I know you are probably not responsible fo that. But do you know of anything that is going on in Mississipp that we can brag about in that area?

Ms. WETHERBEE. I think there is a major health education effort being conducted by the Health Department in several areas, complete with public notices on television and things like that.

What you're saying makes perfect sense, and I agree wholeheartedly. It does raise the question to what extent a program like Medicaid should be paying for nonmedical services which will either have some preventive benefit to avoid health care costs or which would offer an alternative to inpatient hospitalization, which is certainly truly a medical service.

Mr. HOLLAND. The other area that backs into, of course, would be your whole maternal and child health effort, which is basically prevention: get the babies in soon, take care of the pregnant mothers postnatal and the rest of it, which Helen is very heavily involved in along with Dr. Cobb in the State.

Senator COCHRAN. One of the opportunities I had during the last break was to go out and look at a van, a mobile unit that goes around this area providing child care assistance and services from the Aaron Henry Medical Center. It also brings to mind the fact that we do have a lot of people who are in the hard-to-reach areas. The cost of transportation, we talked about that, the fact that that is an impediment, a barrier that somehow needs to be dealt with more effectively.

We have covered a lot of ground and have talked about a lot of different things, and I really am grateful to all of you for being here today and helping to make us think about these things.

The hearing record that we have compiled today will be very helpful to our Aging Subcommittee as I go back to Washington and report to the chairman that we had this hearing and some of the observations that we have heard and suggestions for changes in Administration policies or legislation. We will certainly be sure that they are taken into account by the committee, and I hope that we can see some positive results from that.

We will also try our best to see that some remedy and some solutions are found for the individual problems and special circumstances that have been brought to my attention while I have been here today.

I also want to recognize the fact that Kenneth Williams has been here today throughout this hearing. He is one of our outstanding leaders in the State Legislature and has been for many years, and is a close personal friend. It's good to get a chance to see him here.

I also want to thank Chris Bitsko, who is here from Washington as our court reporter, and who has made sure that this will be a legible and carefully punctuated, and grammatically correct hearing record. We appreciate his assistance very much.

Again, I want to thank all the members of my staff, whom I introduced earlier, for their assistance in arranging the hearing, and to thank Mayor Henry Espy for making available the city auditorium and greeting us as he did when we began the hearing.

If anyone has any comments or statements or suggestions or ideas that ought to be included as part of the hearing record, feel free to send that to me in writing. We would be glad to do that. You can just mail it to me: Senator Thad Cochran, U.S. Senate, Washington, DC. I will get it, and we will put it in the record, and it will have a very important effect on our deliberations.

[The appendix follows:]

ACCESS TO HEALTH CARE FOR THE ELDERLY IN MISSISSIPPI

Presented by
Alton B. Cobb, M.D., M.P.H.
State Health Officer

Thank you for providing me with this opportunity to speak to you regarding access to health care for the elderly. We know that the elderly represent one of the fastest growing population groups in our country. The elderly also utilize health services at a greater rate than other age groups.

People can expect to live longer now than ever before. It is important, however, that these years be as active and independent as possible.

To address the increasingly older population we should endeavor to prevent illness as much as possible, keep the ill from becoming disabled, and help the disabled to preserve function and prevent further disability. We see more and more evidence that changing certain behaviors, even in old age, can improve health and quality of life. Cessation of cigarette smoking, good nutrition, reducing sodium intake, increasing physical activity, and losing weight, for example, can reduce the risk of disease and disability among older adults.[1]

The elderly also need regular primary health care services to preserve good health and prevent disabling diseases and conditions. Clinical preventive services should include the control of high blood pressure, cancer screening (particularly breast in women and prostate in men), immunization against pneumonia and influenza, counseling to promote healthy behaviors, and therapies to help manage chronic conditions such arthritis, osteoporosis, and incontinence.[2] In addition, the growing problem of Alzheimer disease demands further research and development of family oriented service systems.

The State Department of Health provides hypertension and diabetes screening, and assists in managing these conditions through local county health departments. In fiscal year 1990, 3,274 persons were provided hypertension management and 1,192 received diabetes management services through this system.[3] Additional funding to health departments and primary care centers for hypertension and diabetes treatment would be an effective intervention.

The State Department of Health also provided 47,074 immunizations for influenza to persons aged 65 and older during the 1990-91 flu season and 7,888 immunizations for

pneumonia during calendar year 1990. Pneumococcal disease is three times more prevalent among the elderly than younger people. Pneumonia was responsible for an average 48 days of restricted activity for every 100 people aged 65 and older in 1987. The death rate for influenza is 34 to 104 times higher for the elderly as well.[4] Targeted grant support through the Centers for Disease Control for adult immunization programs should be a high priority.

Although the majority of the State's younger elderly persons are relatively healthy, general health and mobility decline with advancing years. About 25 percent of persons aged 85 or older ("frail elderly") are unable to perform essential activities of daily living and require extensive medical and social support in the home or require nursing home care.[5] Few elderly persons can afford extended long term care. The fact that large numbers of our elderly are poor and usually live in isolated rural communities adds to the burden of frail elderly.

Home health services play an important role in providing needed health care for the homebound elderly, but the care is provided on an intermittent basis and is limited to rehabilitative care. The State Department of Health provides home health services statewide through 26 regional offices. In calendar year 1990, the Department provided over 375,000 visits to almost 3,000 homebound elderly individuals. These visits represent an increase of almost 58 percent over the previous year.[6]

Home care for many chronic conditions is ineligible for Medicare reimbursement. Financing of custodial care is unavailable for most. In an effort to address these limitations, the agency is operating a pilot project called "Project Home" in one public health district. This project provides funds to purchase home health services for those who would not otherwise qualify. Although assistance is not limited to the elderly, approximately 63 percent of those served by Project Home are elderly.

Gaps in home-based services include the need for more homemaker services, Meals-on-Wheels, and other support services which would supplement services reimbursed under Medicare and Medicaid and enable elderly persons to continue living in their own homes. Other social support services to enable older persons to install ramps, make home repairs, receive nutritional assistance, and so forth would also help the elderly maintain independence.

Social isolation is both a risk factor for disease and a measure of reduced functional independence.[7] Social support networks are influential in fostering the health

and independence of elderly persons. Depression is a particular problem among older adults; men aged 65 through 74 have the highest suicide rate in the United States.[8] Community support networks not only provide important services to help the elderly remain as independent as possible, they also represent interventions for reducing social isolation.

In Fiscal Year 1990, the Mississippi Council on Aging provided over 4,800,000 units of service to over 85,000 clients throughout the state. These included in-home services[a] to 9,210 clients, community services[b] to 66,513 individuals, and congregate and home delivered meals to 19,848 persons. Approximately 3,000,000 meals were served during this time, with 1,200,000 served in congregate sites and 1,800,000 home delivered. During the fiscal year, there were 2,747 clients on a waiting list for homemaker services and 1,047 for home delivered meals.[9]

Societal trends in the United States have produced smaller family units, as well as fewer unemployed family members, making the option of home care by the family of elderly persons less available. Financing for physician care and medication is becoming more difficult for the elderly as Medicare deductibles and co-insurance payments increase.

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[a] In-home services include case management, homemakers, home health aides, visitation and telephone reassurance, residential repair, special needs, emergency response, Medicaid waivers, and chore maintenance.

[b] Community services include transportation, outreach, information and referral, respite care, ombudsman, senior citizen activities, and legal and senior discount.

For many, nursing home care is necessary. Medicaid is the primary payor for this expensive care. To become eligible for Medicaid nursing home care, one must "spend down" to Medicaid eligibility levels, often leaving an impoverished elderly spouse at home. Recent federal changes in this "spend down" rule have provided more support for the spouse. Because it is so expensive, the number of nursing home beds for which Medicaid will pay is very limited, making access even more difficult. Although the state legislature has added authorization for several hundred additional nursing home beds in the last few years, planners estimate that an additional 570 beds are needed at present.[10]

Another approach to addressing social isolation is special congregate housing for the elderly. In my opinion, we need to use this increasingly as a more economical model than in-home services or the traditional nursing home.

Providers of primary health care are critical in the promotion of good health and functional independence of the elderly. In addition to providing appropriate clinical preventive services such as screening, counseling, and immunizations, they can monitor health status to detect early signs of other conditions that can jeopardize independence such as dementia or depression. Providers can help supply information and referral to available services, given appropriate training.

We need more family physicians with training in Geriatrics. There are only a few hundred physicians in the United States who are trained in geriatric medicine.

In addition, geriatric nurse practitioners could provide on-site services in nursing homes and free a need for more intensive health supervision both in such facilities and at primary care sites.

The Geriatric Education Center of the University of Mississippi Medical Center has provided professional education services for the past five years. Center staff have, over the past two years, certified 450 people of various specialties, primarily nurses and social workers. Additionally, training has been provided to 1,500 to 2,000 individuals in courses sponsored by the Center.

The Center is currently expanding its scope of operations by providing training to the faculties of eight community colleges and the five historically black colleges. Other recipients of training are representatives of the Choctaw Indian tribe and the U.S. Naval

Home. Training focuses on development of service and activity programs for elderly in the community utilizing models developed in Virginia and California."

We must examine ways to provide proper health care services for the elderly population. New Medicaid options which allow coverage of about 30,000 additional elderly persons with incomes up to 100 percent of the poverty level will help. Home and community-based services, respite care, day care, and supplemental food programs should be expanded or initiated. The elderly deserve to receive appropriate health care services which not only will allow them to enjoy a good quality of life, but will allow them to remain at home as long as possible.

ENDNOTES

1. *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*. U.S. Department of Health and Human Services, Publication No. 91-50212, p. 24.

2. Ibid, p. 25.

3. FY 1990 Patient Registrations. Mississippi State Department of Health.

4. *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*. U.S. Department of Health and Human Services, publication No. 91-50212, p. 25.

5. 1990 State Health Plan. Mississippi State Department of Health.

6. Division of Home Health. Mississippi State Department of Health.

7. *Healthy People 2000*, p. 26.

8. *Healthy People 2000*, p. 26.

9. *1990 Report on Activities*, Council on Aging, Mississippi Department of Human Services.

10. 1990 State Health Plan. Mississippi State Department of Health.

11. Geriatric Education Center, University of Mississippi Medical Center.

DEPARTMENT OF MENTAL HEALTH

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May 1, 1991

ACCESS TO HEALTH CARE FOR THE ELDERLY

"What is being done to address barriers to access, and what more should be done?"

On behalf of the Mississippi Department of Mental Health and the State Board of Mental Health, I would like to express our appreciation for this opportunity to provide input to increasing access to health services for elderly persons. I will briefly summarize some of the efforts to address barriers which we have been involved in or of which we are aware; however, most of my comments will focus on observations and recommendations for improving access to appropriate services for elderly persons.

What is being done.

Background/Current Initiatives

In 1985 and 1986, interagency task forces comprised of representatives from various state mental health, health, aging and other social service agencies, as well as representatives of professional organizations and federal agencies concerned with the service needs of elderly persons, identified the services available at that time to elderly mentally handicapped Mississippians, including persons with developmental disabilities and mental illness. The task forces made recommendations for further planning and coordination of service delivery to the overall population of elderly mentally disabled persons in the areas of alternative living arrangements, day services, support services, training needs and funding. Some major issues the task forces supported included the need for more detailed assessment by mental health region or county to more accurately define possible gaps in services and the need for increased cross-training of service providers (in both the fields of mental health and aging) in such areas as normal aging, the mental health needs of elderly persons, and medication use and misuse (Services for Elderly Mentally Handicapped Mississippians, A Coordinated Plan, June 1, 1986). Since that time, efforts to increase cross-training of service providers across the aging, health and mental health/developmental disabilities fields have continued. Some specialized programs for elderly persons with mental retardation, such as a Pre-Retirement Program and Retirement Group Homes operated by the Boswell Retardation Center and the Hudspeth Retardation Center have also developed; and, some efforts are being made to access senior services where they exist and are appropriate for elderly persons with mental retardation. The Department of Mental Health has also worked with other state agencies on the OBRA Interagency Committee to develop and implement screening, evaluation and treatment requirements contained in the Omnibus Budget Reconciliation Act of 1987 and subsequent federal legislation pertaining to nursing home services.

In further efforts to identify and address the specialized mental health needs of elderly persons in Mississippi, the Elderly Task Force, an interagency committee, was established in 1989 by the Department of Mental Health through the Mississippi State Mental Health Planning Council. Building on earlier planning efforts in 1985 and 1986, the Elderly Task Force identified as the major issue it would address the need to facilitate linkages among existing services for elderly persons and mental health services at the local level. The Task Force is seeking first to where possible work to eliminate institutional barriers across agencies serving elderly persons to improve service access and coordination. The group also hopes to work to expand cross-training and support linkages with academic institutions, such as the local training network being built through the Geriatric Education Program at the University of Mississippi.

Support was expressed by state representatives of key provider agencies/entities for an initiative to facilitate communication among key providers of services to elderly persons, including individuals with mental disabilities at the local level; for increasing awareness across providers of available services; and, for assisting providers in developing more effective service linkage or coordination at the local level. The initial step in the initiative will be a series of 10 regional meetings, hosted by regional community mental health/mental retardation centers, among the key service providers in local communities to address these objectives.

What more should be done.

Recommendations/Areas of Need

1) Coordination of existing services should continue and be supported at the federal level by coordination of resources and regulations across federal agencies administering various programs for elderly persons. Clear identification of the agencies (federal and state) responsible for implementation and funding of services would facilitate efforts in state and local service coordination.

2) Access to existing senior services by elderly persons with mental disabilities, when appropriate, should be continued and expanded.

3) Elimination of institutional boundaries to treatment should be a goal of agencies serving elderly persons, beginning at the federal level. For example, mental health services should be provided in nursing homes if necessary and off-site when possible and most appropriate to meet individuals' needs.

4) Services should target those persons most at-risk and isolated with aggressive outreach. Programs should be designed to avoid the tendency to serve those who are easiest to reach. Often those persons who are most isolated are also the most in need and are less likely to refer themselves or to have a supportive relative or friend to refer them for services. Support services such as case management and transportation are vital in reaching such persons in need.

5) Provision of services based on level of functioning and available formal and informal (families, friends, etc.) support systems, rather than solely on diagnosis, should be facilitated.

6) Services for elderly persons should include strong medical, social and psychological components to meet the total needs of individuals and their families.

7) Strategies to be more supportive of families and caregivers should be developed, such as increasing the availability of education and support groups for families/caregivers.

8) Cross-training of service providers in the aging, health, mental health, and other social service fields should continue to be expanded, including linkages with academic institutions to develop specialized training programs. Development of specialized training initiatives in mental health, mental retardation and aging, through mechanisms such as student stipends, training grants, etc., would help

address the need for professionals with adequate skills to assess and address the service needs of elderly persons and their families. Professional in fields such as psychiatry, psychology, social work and nursing must be more aware of the special needs and problems of elderly persons.

9) Day services for persons with serious mental illness, mental retardation, and dementias should be developed.

10) Resources for providing appropriate and necessary support services for elderly individuals with mental illness or mental retardation in public housing should be available.

11) Future public education efforts should include basic facts about aging, possible service needs and ways to access services. Education about aging might be included in health curricula taught at both the high school and college level.

Respectfully Submitted,

Albert R. Hendrix, Ph.D.
Executive Director
Mississippi Department of Mental Health

ISSUES AND PROBLEMS OF RURAL HEALTH CARE

by

L. C. DORSEY, D.S.W., L.C.S.W.

Demographic Profile

Based on 1980 census for Mississippi, 11.5 percent or 289,000 citizens were 65 or older. Approximately 94,100 or 33% of this group are African American (U.S> Census, 1990).

Most of Mississippi's population lived in rural areas or small towns in 1980. Minority elderly and elderly females who lived in rural areas have the lowest incomes of all Mississippians. Over fifty-one percent (51.4%) of African American elderly live in poverty in our state compared to 25.7 percent of white elderly with poverty-level incomes. The median income for elderly white men was $5,213 compared to $2,926 for African American men. The median income for white womens 65 and older, was $2,998 compared to $2,438 for African American women 65 and older (U.S. Census, 1980).

Health Status

The rural elderly are more likely than urban elderly residents to be afflicted with chronic illness; 41 percent compared to 36 percent (Health Care in Rural America, 1990).

Health care utilization rates for the rural elderly is less frequent than the urban elderly in nearly all categories (Health Care in Rural America, 1990). The evidence suggest that the rural elderly are not often disabled by chronic and acute disease, but fewer visits to physicians are not completely explained by the more favorable health status of the rural elderly in comparison with the urban elderly. The explanation is related to economics and physical difficulties experienced by the rural elderly in gaining access to the health care system (Health Care In Rural America, 1990).

The rural elderly is more frequently hospitalized for shorter stays and for so called "high variation" conditions; cases where physicians differ in opinions regarding the appropriateness of hospitalization, and includes pneumonia, gastroenteritis, angina, and bronchitis (Health Care In Rural America, 1990).

Access to Health Care

For the rural elderly in Mississippi, there are two major and several minor barriers to health care. The major barriers are economics (money or health insurance to pay for health care) and transportation to and from the health care provider. Minor barriers includes health care seeking behavior values, reliance on traditional healing systems and inadequate education about health maintenance, disease prevention and wellness.

Access: economics

Rural America and the rural elderly is characterized (and perhaps romanticized) as proud, independent and highly individualistic people. These traits often carry over into health care seeking behavior, and may prevent seeking health care if the perception of charity is attached. Consequently, rural families may not seek health care if there is no money to pay for it. This is especially true of many older rural citizens who often fail to seek health care because they have no means of payment. Because their value system is centered around payment of their obligations (and being true to their word) they are more careful about making debts.

Over 690,000 people or 26 percent of the state's population are uninsured with no protection against the high cost of becoming ill. Only 54 percent of those eligible for medicaid, including many elderly citizens, are actually enrolled in the program. (Report of the Governor's Select Committee on Indigent Health Care, January, 1989).

Additionally, there are thousands of people who are eligible for medicare, who fear that they will lose their homes or life savings if they become ill or have to be [illegible]

Access: Transportation and Availability of Providers

Access to health care providers for elderly rural Mississippians is often a major problem. The formula for adequate physician patient ratio in Mississippi is: one primary care physician to 2,000 population. The 1988 ratio of primary care physicians to population is 1:1,684, however, 53.7 percent of all primary care physicians live and practice in eight counties which include the state's larger urban centers. (Report of the Governor's Select Committee on Indigent Health Care, January 11, 1989). The most popular formula for determining adequate health manpower in an area is to count the number of primary physicians. Often this formula does not include the problems of physicians who prefer not to treat medicaid patients, patient transportation child care or patient preference in selecting a provider. Some physicians are perceived not to be courteous or to be racist to poor or non-white patients. Often patients will delay seeking care if this perception exists with the only provider in their immediate surroundings.

Many of the rural elderly are non-drivers and are dependent on public transportation and neighbors for rides to the doctor; often paying from $10.00 - $40.00 per trip. Since both sources of transportation may not be efficient or affordable, transportation is a factor in how frequently health care is sought. In the meantime, many rural elderly Mississippians have adopted a system of self-care to compensate for the lack of money for health care and/or

insurance. An alternative health care system utilizing over-the-counter (OTC) medicines and products, herbal products, and spiritual exercises comprise the home remedies which is the major health care of some rural families (Charles Champion, Pharm.D., interview, 1988)

In a 1983 study by the Rural Health Research Program of the University of Mississippi, researchers found that 39.74 percent of rural Mississippians believed home remedies were more effective than seeing physicians (N=1724). Eighty percent of Blacks surveyed (N=997) and 19 percent of whites (N=727) believed in the medical superiority of home remedies over physicians. Perhaps, predictably, those included in the sample who were less well educated, were more inclined to believe that home remedies were more effective than physicians. On the other hand, disabled participants in the sample (N=222) strongly disagreed with the statement that home remedies were better than physicians. (Baseline).

There was significant correlation between arthritics and sufferers of heart disease and participants who believed that home remedies were better than treatment by physicians. Tests for correlation between diabetic participants and participants who favored home remedies were insignificant; however, the most telling statistic in the survey was the association of participants who had difficulty getting to a doctor with the statement that home remedies are better. Almost 40 percent (or 647) of the participants who had difficulty getting to a doctor believed home remedies were better (N=1647). (Baseline population Survey, Dennis Frate, Rural Health Research Program, University of Mississippi, 1983).

Overcoming The Barriers To Health Care For The Elderly

The elderly are a special population who has paid its dues in the Mississippi workplace; whether on plantations, in department stores, classrooms, or as domestics or factory workers. They have paid taxes and supported progress for the next generation. Many saved money for their retirement; never expecting the cost of illness to be as expensive as it is today. We owe it to this generation to find a way to meet their health care needs that is efficient, cost effective and humane.

Preventive health care offered at community health centers* at prices based on family size and income is the best investment of the tax dollars in community health care in the past 25 years. At this point, the state does not fund community health centers, but 5-10 percent matching grants from the state earmarked for special risk populations such as the elderly or the frail elderly could expand the scope of community health centers' services to the rural elderly through outreach services and increased visits to the centers.

Disease Prevention, Health, Promotion and Public Awareness

Rural Mississippians receive less direct information about disease prevention and health promotion than residents of cities. Health educators often are not any more available than doctors to rural residents. The evidence of the need for patient education should be evident when compared to the literacy rate. Often detailed written instructions are given to the patient with the prescription and a one minute oral presentation of the instructions for use. Doctors at Delta Health Center report incidents of having patients return to the clinic for a follow-up visit only to learn that the medication has not been taken because of the failure to understand both the written or oral instructions. One

* Note: Comprehensive medical, dental, services located in one location.

example; which addresses two issues in rural Mississippi; literacy and economics, is demonstrated in this account by a former physician who saw a patient on a return visit who had not taken any of one medication that he prescribed. When he asked the patient why he hadn't taken the pills which he had prescribed to be taken with orange juice, the elderly patient patiently explained that he hadn't taken them because he had not had any orange juice.

Community health centers can offer quality health care and health education to elderly rural Mississippians. The cut back in funding over the past few years, has significantly curtailed disease prevention and health promotion activities including health counselors and other outreach workers. Coupled with an improved public transportation system, each center has adequate space to meet a significant percentage of the health and health education needs of their service areas and beyond. However, the emphasis on limiting funding to fee-generating services limits the amount of preventive health care education capacity of most centers. The benefits of educating a patient population is supported by the success rate of the anti-smoking campaign and other highly publicized disease targeted campaigns (i.e., high blood pressure detection). A more informed elderly population is also less susceptible to fear of seeking health care and the expected indebtedness, as well as the health consequences of delaying seeking health care services from physicians and other health care professionals.

Conclusion

A nation with the capability to conquer space and tread on the moon's surface has the potential of removing the fear of becoming ill from all of it's citizens. The "kinder and gentler nation" that the President has called for, should include access to adequate, affordable health care for all Americans including Mississippi's rural elderly citizens.

ACCESS TO HEALTH CARE FOR THE ELDERLY
COMMENTS PREPARED FOR
[illegible]
SUBCOMMITTEE ON AGING
CLARKSDALE, MISSISSIPPI
MAY 1, 1991

INTRODUCTION

Good Morning Mr. Chairman:

My name is Robert C. Jackson, I am the Director of the Public Health Service, Division of Community Health Services representing the Regional Health Administrator, Public Health Service (PHS) Regional Office in Atlanta. It is my intent to describe the current operations of the Community Health Centers (Section 330 of the Public Health Service Act) and the National Health Service Corps in the State of Mississippi. Given the broad array of PHS programs administered through grants or cooperative agreements in the State, these programs, plus one special demonstration project, represent the efforts most directly relevant to health care access problems experienced by elderly citizens in this State.

I. Registered Patients in Community Health Center Practices

During CY 1990, there were 16,269 registered patients aged 65 and over in Community Health Centers (CHC) in Mississippi. They represent 10.9 percent of all patients in these primary care practices. Nearly twice as many individuals received care in rural sites as in urban locations (Table I).

TABLE I

Health Center Patients in Mississippi
Total Users and Elderly Users
CY 1990

	Total Users	Users Aged 65 & Over	% of Users 65+
Urban	64,285	5,554	8.6%
Rural	84,471	10,715	12.6%
Totals	148,756	16,269	10.9%

Examination of the management information reports from Mississippi Community Health Centers reveals a considerable range among the CHCs regarding the numbers and percentages of elderly citizens being served. In one rural site, 29.3 percent of patients are elderly; in one of the urban sites, only 3.3 percent are aged 65 or over. But, as Table I suggests, utilization of CHC services by the elderly is overall much higher in rural areas. For the majority of CHCs, elderly patients represent 7.5 to 15 percent of registrants.

With regard to trends, Table II graphically illustrates that CHC use by elderly citizens is increasing in a dramatic fashion.

TABLE II

Patients Aged 65 and Over
In Mississippi CHCs
CY 1987 - CY 1990

1987	1990	% Increase 1987-1990
10,800	16,300	51%

II. Resources to Support Primary Care and Related Services for Elderly Citizens

The allocation of Section 330 dollars for support of CHCs in Mississippi will be $18,791,155 by the end of Fiscal Year 1991. This represents a 11 percent increase since 1986. Since the Health Centers receive only about 64 percent of their total operating costs from grant funds, the level of other reimbursements, especially Medicare and Medicaid, becomes central to any discussion of resources.

Table III

Mississippi Health Center Revenues
By Source, CY 1990 and Percent
Change Since 1986

Source	1990	%Change Since 1986
Medicaid	4,325,599	269%
Medicare	1,572,192	45%

In addition to fiscal resources, the growth of primary care services in Health Centers has been highly dependent on the availability of obligated health care providers from the National Health Service Corps scholarship program, and more recently, the availability of participants in the Loan Repayment Program.

As of April, 1991, there are 99 Nation Health Service Corps clinical providers working in settings throughout the State of Mississippi who provide primary care and related services.

TABLE IV

NHSC/CHC Providers in
Mississippi, April 1991

NHSC-Related*	39	Physicians
Hired by CHCs	45	Physicians
	15	Mid-levels
Total	99	

*Federal Obligated - 2
Federal non-obligated - 2
Private Practice Assignment - 30
Private Practice Option - 3
Private Practice Salaried - 2

Since July 1990, eleven NHSC providers have been matched or obligated to Mississippi sites. An additional four matches are pending at this moment. To maintain the current level of services, the goals for provider placement for 1991 are:

	SLOTS
Health Professional Opportunity List (Obligated Scholars)	10
Loan Repayment (Volunteers)	13

Given that the preponderance of successful recruitment occurs between May and September, we are confident that the 23 vacancies will be reduced.

Before leaving this overview of resources for services to the elderly, I wish to bring to your attention the PHS grant to the Mississippi Department of Public Health for Health Care Services in the Home. The program, which is one of only five in the country, is now operational in Public Health District IV. The purpose of the program is to demonstrate ways to avoid unnecessary hospitalization of persons who can be cared for at home.

III. Future Plans

Within the next few weeks, the Federal Register will announce the availability of Fiscal 1991 funds for New Start and Expansion activity by Community Health Centers. While the applicants must compete nationally for the available dollars, there are two communities in Mississippi identified by the Public Health Service as representing unusual need and opportunity.

For several years, the Bureau of Health Care Deliver and Assistance (BHCDA) has funded a Primary Care Cooperative Agreement to the Mississippi Department of Public Health. Implemented through a three-party Memorandum of Agreement, the State Department of Public Health, the Mississippi Primary Care Association and BHCDA have worked to increase resources for primary care and to strengthen cooperation among providers of personal health services, particularly primary care. In Fiscal Year 1992, one of the objectives of the Cooperative Agreement will be county-level needs assessment and planning to identify the areas of greatest need for primary care.

The last item I wish to mention is the long-standing relationship between the Bureau of Health Care Delivery and Assistance and the Administration on Aging. Five years ago, we began State-based efforts to increase cooperative activities between CHCs and Area Agencies on Aging. Earlier in April, 1991, the Region IV Office of the Public Health Service co-sponsored with the Administration on

Aging, a Regional conference on health promotion services for older citizens. The program represented a survey of current approaches to disability prevention and health maintenance. Our next step will be encouragement that these innovations in services be made more widely available, particularly to the rural minority elderly. Also, given that utilization of CHC services by elderly people is growing, we wish to reinforce this trend by returning to the Area Agencies on Aging to review service coordination. In rural areas, particularly, we will be looking at transportation.

Thank you for the opportunity to comment.

I AM SHELBY C. HOWELL, M.D., A PHYSICIAN PRACTICING EMERGENCY MEDICINE HERE IN COAHOMA COUNTY. I APPRECIATE THIS OPPORTUNITY TO EXPRESS SOME OF MY VIEWS, AS WELL AS THE VIEWS OF ORGANIZED MEDICINE, ON THE QUESTIONS WHAT ARE THE BARRIERS TO ACCESS TO THE HEALTH CARE SYSTEMS FOR MISSISSIPPI'S ELDERLY AND WHAT CAN BE DONE TO ADDRESS THESE PROBLEMS.

I BELIEVE ALL MISSISSIPPIANS SHOULD HAVE ACCESS TO QUALITY HEALTH CARE AT A REASONABLE COSTS. UNFORTUNATELY, MISSISSIPPI HAS A DISPROPORTIONATE SHARE OF POOR, UNSKILLED AND ELDERLY PEOPLE. NATIONALLY 13% OF RURAL RESIDENTS ARE ELDERLY, AS COMPARED TO 9 % FOR URBAN ARES. IN 1989 THE UNITED STATES CENSUS BUREAU ESTIMATED THAT THERE WERE 320,000 OVER THE AGE OF 65. OF THOSE, ALL QUALIFY FOR MEDICARE AND 57,395 ARE ELIGIBLE FOR MEDICAID. IN 1990, 58 OF MISSISSIPPI'S 82 COUNTIES WERE DESIGNATED IN WHOLE OR PART AS HEALTH MANPOWER SHORTAGE AREAS. PHYSICIANS ARE [illegible] AT AN ALARMING RATE DUE TO LOW REIMBURSEMENT FOR HEALTH CARE PROVIDERS THROUGH MEDICARE AND MEDICAID. THE PROBLEMS WE FACE ARE MYRIAD, HOWEVER SOLUTIONS TO MISSISSIPPI'S HEALTH CRISIS DO EXIST. PUBLIC AND PRIVATE ENTITIES MUST WORK TOGETHER TO DEVELOP CREATIVE [illegible] IN THE CURRENT STRUCTURE OF RURAL HOSPITALS, INCREASE REIMBURSEMENT TO PHYSICIANS AND HOSPITALS THROUGH MEDICARE AND MEDICAID, PROVIDE INCENTIVES FOR NEEDED HEALTH CARE PROFESSIONALS TO SERVE THE RURAL POPULATION AND MAINTAIN THE QUALITY OF ESSENTIAL HEALTH CARE SERVICES.

WHY ARE RURAL HOSPITALS CLOSING? WHY ARE PHYSICIANS AND OTHER HEALTH CARE PERSONNEL SO DIFFICULT TO RECRUIT AND RETAIN IN THESE AREAS? THE COMPLEX ANSWERS TO THESE QUESTIONS COVER A WIDE RANGE OF SOCIAL, CULTURAL, LEGISLATIVE, TECHNOLOGICAL AND ECONOMIC ISSUES WHICH MAKE INTERVENTION DIFFICULT.

WITHOUT HOSPITALS, PHYSICIANS HAVE NO INPATIENT FACILITY TO PROVIDE ACUTE CARE SERVICES OR TO DEAL WITH MEDICAL EMERGENCIES THAT ARISE FROM EXPOSURES TO DANGEROUS ENVIRONMENTS.

RURAL RESIDENTS ARE NINE TO TEN TIMES MORE LIKELY THAN URBAN RESIDENTS TO DIE FROM INJURIES INVOLVING LIGHTNING, EXPOSURE, MACHINERY OR NATURAL DISASTERS. IN RECENT YEARS RURAL HOSPITALS HAVE HAD DECLINING ADMISSIONS AND LOWER OCCUPANCY RATES AT TH SAME TIME THEY HAVE PROVIDED A GREATER PROPORTION OF UNCOMPENSATED CARE. THEY ARE DEPENDENT ON FEDERAL PROGRAMS SUCH AS MEDICARE FOR REIMBURSEMENT, THEIR REVENUES AR DECLINING AND COSTS ARE RISING AS THE DEMAND FOR MODERN MEDICAL TECHNOLOGY, SKILLED PERSONNEL AND BETTER FACILITIES INCREASES. UNDER THE CURRENT MEDICARE PROSPECTIVE PAYMENT SYSTEM RURAL HOSPITALS RECEIVE FROM 11% TO 15% LESS REIMBURSEMENT THAN THEI URBAN COUNTERPARTS FOR EXACTLY THE SAME SERVICE. HISTORICALLY, MEDICARE REIMBURSEM HAS NOT KEPT PACE WITH INFLATION AND MEDICARE MARGINS FOR RURAL HOSPITALS DECREASED FROM 7% TO -2.4%.

I WOULD LIKE TO SUGGEST THE FOLLOWING POSSIBLE SOLUTIONS. ON THE FEDERAL LEVEL CONGRESS SHOULD:

1. REFORM AND FULLY FUND THE MEDICARE/MEDICAID PAYMENTS SYSTEMS TO INSURE FAIR, ADEQUATE REIMBURSEMENT FOR ALL PROVIDERS. ARBITRARY, BUDGET-DRIVEN REDUCTIONS PROVIDER PAYMENTS SHOULD CEASE.
2. PROVIDE FUNDING AND A MANDATE TO ESTABLISH A NATIONAL PAYMENT STANDARD, FAIRLY AND REASONABLY ADJUSTED FOR DEMONSTRATED DIFFERENCES IN HEALTH CARE COSTS, RESOURCES AND MEDICALLY APPROPRIATE UTILIZATION.
3. FUND AND MANDATE THE ELIMINATION OF THE URBAN/RURAL PPS PAYMENT DIFFERENTIAL PRIOR TO 1995.
4. FULLY FUND HOSPITAL CAPITAL INVESTMENTS REQUIRED TO MEET STATE AND FEDERAL [illegible] FOR THE PROVISION OF CARE TO MEDICARE/MEDICAID BENEFICIARIES.
5. ESTABLISH AND FUND A NATIONAL FLOOR FOR MEDICAID COVERAGE AND BENEFITS, TO INSUR ACCESS TO HEALTH CARE.
6. PROVIDE ANNUAL HOSPITAL RATE UPDATES.

WHILE PHYSICIANS NEED HOSPITALS IN ORDER TO PROVIDE CERTAIN TYPES OF CARE, WITHOUT PHYSICIANS, THE HOSPITALS ARE EMPTY BUILDINGS.

APPROXIMATELY 53.7% OF THE STATE'S 1,614 PRIMARY CARE PHYSICIANS LIVE AND PRACTICE I 8 OF MISSISSIPPI'S MOST POPULOUS COUNTIES. PHYSICIANS ARE DIFFICULT TO RECRUIT TO RURAL AREAS FOR BOTH PROFESSIONAL AND PERSONAL REASONS. PROFESSIONALLY, RURAL PHYSICIANS ARE OFTEN ISOLATED FROM THEIR PEERS. THERE ARE FEW INDIVIDUALS WITH WHOM THE PHYSICIANS CAN READILY EXCHANGE IDEAS, EXCHANGE OPINIONS OR CONSULT ABOUT UNUSUA PHENOMENON OR LITTLE-USED PROCEDURES. CONTINUING EDUCATION IS HARD TO ARRANGE.

ON A PERSONAL LEVEL, PHYSICIANS OFTEN DECLINE TO PRACTICE IN RURAL AREAS BECAUS THE ENVIRONMENT IS UNFAMILIAR, THEY HAVE LARGE EDUCATION DEBTS THEY MUST REPAY AND T EDUCATIONAL AND SOCIAL OPPORTUNITIES ARE OFTEN LIMITED.

THE RURAL PHYSICIAN IS OFTEN OVERWORKED AND UNDERPAID IN COMPARISON TO URBAN COLLEAGUES. HE OR SHE DOES NOT READILY HAVE RELIEF AVAILABLE FOR BACKUP FOR EMERGENCY SITUATION OR FOR TIME OFF. MEDICARE PAYMENTS FOR PHYSICIANS' SERVICES TO RURAL BENEFICIARIES ARE CONSISTENTLY LOWER THAN FOR URBAN BENEFICIARIES, EVEN THOUGH THE SERVICE PROVIDED IS INDISTINGUISHABLE. BECAUSE ELDERLY MEDICARE PATIENTS CONSTITUTE A LARGER SHARE OF THE RURAL PHYSICIAN'S PRACTICE THAN AN URBAN PHYSICIAN'S, COST CONTAINMENT MEASURES SUCH AS FEE FREEZES ARE ESPECIALLY DEVASTATING TO RURAL PHYSICIANS. ANOTHER FACTOR FACING RURAL PHYSICIANS IS THE COST OF MEDICAL LIABILITY INSURANCE. FAMILY PRACTICE PHYSICIANS, EMERGENCY MEDICINE PHYSICIANS AND OBSTETRICIANS HAVE SEEN MALPRACTICE INSURANCE PREMIUM COSTS INCREASE FASTER THAN OTHER SPECIALTY GROUPS.

I WOULD LIKE TO PROPOSE THE FOLLOWING SOLUTIONS TO SOME OF THESE ISSUES FACING RURAL PHYSICIANS. ON THE FEDERAL LEVEL CONGRESS SHOULD:

1. RESTORE THE INCOME TAX DEDUCTION FOR EDUCATION LOAN INTEREST FOR PHYSICIANS WHO PRACTICE IN MEDICALLY UNDERSERVED AREAS OR HEALTH MANPOWER SHORTAGE AREAS.
2. INCREASE THE FUNDING FOR NATIONAL HEALTH SERVICE CORPS, PARTICULARLY FOR THE PHYSICIAN LOAN REPAYMENT PROGRAM.
3. PROVIDE ADDITIONAL FUNDING FOR COMMUNICATION LINKAGES WITH REFERRAL TEACHING CENTERS TO PROVIDE CLINICAL CONSULTATION AND CONTINUING EDUCATION TO RURAL PHYSICIANS.
4. PROVIDE FUNDING FOR RELIEF SERVICES TO ALLOW RURAL PHYSICIANS TO LEAVE THEIR [illegible]
5. PROVIDE FUNDING INCENTIVES FOR MEDICAL SCHOOLS, NURSING SCHOOLS AND SCHOOLS OF ALLIED HEALTH TO ADMIT STUDENTS FROM RURAL AREAS WITH MANDATED PAYBACK TIME.
6. REQUIRE THAT RURAL AND URBAN PHYSICIAN REIMBURSEMENT BE EQUALIZED.
7. IMPLEMENT THE RESOURCE BASED RELATIVE VALUE SCALE (RBRVS) WITH A FLOOR FOR MEDICARE PAYMENTS TO RURAL PHYSICIANS EQUAL TO THE AVERAGE PAYMENTS TO URBAN PHYSICIANS AND USING A METHODOLOGY THAT ACCURATELY REFLECTS THE GEOGRAPHIC AREAS IN WHICH PHYSICIANS DELIVER SERVICES.
8. PROVIDE THE FUNDING FOR STATE INDEMNIFICATION PROGRAMS FOR PROFESSIONAL LIABILITY CLAIMS RESULTING FROM THE PROVISION OF SERVICES TO MEDICAID PATIENTS, THE INDIGENT AND PARTICIPANTS IN OTHER FEDERAL HEALTH PROGRAMS.
9. PASS LEGISLATION TO ALLOW ANNUAL TAX DEDUCTIONS FOR "INSURANCE LIABILITY TRUST", SET UP ESPECIALLY TO FUND LIABILITY INSURANCE PREMIUMS BASED UPON THE PERCENTAGE OF MEDICARE/MEDICAID PAYMENTS TO THE TOTAL DOLLAR VOLUME OF ALL PAYMENTS.

10. PROVIDE FEDERAL INCENTIVES FOR STATES TO PASS TORT REFORMS SUCH AS NON-ECO DAMAGE CAPS, PERIODIC PAYMENTS AND ELIMINATION OF THE COLLATERAL SOURCE RU

OVER 40% OF THE MISSISSIPPI MEDICAID PROGRAM BUDGET IS UTILIZED TO PAY FOR NURSING HOME CARE FOR MISSISSIPPI'S ELDERLY. THERE IS HEAVY DEPENDENCE ON NURS HOMES TO PROVIDE THE MAJORITY OF LONG TERM CARE AND FEW VIABLE NON-MEDICAL HOUS OPTIONS AVAILABLE FOR THE FUNCTIONALLY IMPAIRED ELDERLY PEOPLE. IN THIS STATE, ARE OLD AND POOR, AND NEED LONG TERM HEALTH CARE SERVICES YOU ARE MOST LIKELY BI FOR A NURSING HOME. THERE IS A NEED FOR A MORE BALANCED LONG TERM CARE SYSTEM I EMPHASIS ON ALTERNATIVE SERVICES SUCH AS: 1. CASE MANAGEMENT PROGRAMS FOR THE ELDERLY; 2. PERSONAL CARE HOMES WITH HOME HEALTH MONITORING; 3. CONGREGATE HOUS ADULT DAY CARE PLANS; AND 5. ADULT FOSTER HOME CARE.

I RECOMMEND THAT CONGRESS REQUIRE THAT STATES PROVIDE THESE ALTERNATIVES TO TERM CARE THROUGH THEIR MEDICAID PROGRAMS.

INNOVATIVE APPROACHES ARE NEEDED TO SOLVE THE PROBLEM OF ACCESS TO HEALTH FOR THE ELDERLY. IN 1989 THE MISSISSIPPI STATE MEDICAL ASSOCIATION, IN COOPERA WITH THE MISSISSIPPI COUNCILS ON AGING, IMPLEMENTED A VOLUNTARY ASSIGNMENT PROG NEEDY MEDICARE BENEFICIARIES CALLED "SENIOR CARE". THIS PROGRAM PROVIDES NAMES PHYSICIANS TO LOW INCOME MEDICARE BENEFICIARIES WHO MAY BE RELUCTANT TO SEEK HE SERVICES BECAUSE OF FINANCIAL BARRIERS IMPOSED BY MEDICARE DEDUCTIBLES AND CO-INSURANCE. "SENIOR CARE" SERVICES WERE PROVIDED TO 1,303 ELDERLY MISSISSIPPIANS STATEWIDE FROM JANUARY 1990 TO FEBRUARY 1991.

[illegible] COLLECTIVE, CREATIVE AND INNOVATIVE APPROACHES WITH ALLIANCES BETWEEN FEDERAL, S AND LOCAL GOVERNMENTS, HEALTH CARE PROVIDERS AND MISSISSIPPI'S COMMUNITIES.

THANK YOU VERY MUCH FOR THIS OPPORTUNITY TO EXPRESS MY OPINIONS ON THIS IMP MATTER.

Mary P. Curtis Ed. D., R.N.,C.

Associate Professor
Mississippi University for Women
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Potential Options for Access to Health Care for Elders

As the new demographic balance continues to evolve in which the elderly population outweighs the younger population, nurses with expertise in gerontology must assume an increasingly important role in the health care delivery system. This role demands a greater degree of independence and leadership than has been customary in the past. Gerontological nursing has evolved to include both generalists and specialists and requires in-depth knowledge, clinical competence, and decision-making expertise warranted by the complexities of the aging process and unique to each aging person. The generalist functions in a variety of settings including hospitals, nursing homes, and public health agencies; provides care primarily to individuals and families; and participates in planning, implementing, and evaluating nursing care. The generalist gleans direction and support from the specialist. The gerontic specialist requires a minimum of a master's degree with a focus in gerontology. In addition to fulfilling all of the requirements of the generalist, this nurse has developed substantial clinical expertise with not only individuals and families, but with communities; is involved with health and social policy; and is proficient in planning, implementing, and evaluating geri-health programs (ANA, social policy statement, (1980). In Mississippi, this category is primarily represented by Nurse Practitioners.

Mississippi, once one of the states with the lowest proportion of aged citizens, is now among the states with the greatest proportion of its population in the elderly category. In accordance with national indicators, the rise in the number of elders is specially great in the "old-old" category or those 85 or more years of age. In the same time period as the proportion of elderly barely doubled in the nation, from 5.4 to 11.3 percent between 1930 and 1980, Mississippi's elderly more than tripled from 3.6 to 11.5 percent. While the population of this state is expected to increase by 33 percent between 1980 and 2050, the elderly population is anticipated to increase by 143 percent (Saunders, 1987).

Since this age group is increasing in numbers so rapidly, health providers must meet the challenge of identifying and implementing innovative low cost arrangements for the provision of quality care for elders including, the old old group. As a family nurse practitioner with expertise in gerontology, I offer the following testimony relevant to what I perceive should be done to facilitate elders access to health care, what interventions have been successful in eliminating this dilemma, either in MS or elsewhere, and what the role of the Federal government might be in order to expedite solutions. In accordance with the American Nurses Association and the National League for Nursing, I support the model of health care that not only looks at disease processes but at health promotion. This model requires that health care providers to be accountable for the continuity of care provided to (MS) consumers and whenever possible nurses should be the health care provider who monitors that care. Inherent in this care is access to that care by the consumer. I believe that federal policy must be reformed to allow for the inclusion of gerontological specialists as providers in Medicare and Medicaid programs. The federal government has done much to support the education of these specialists, but has virtually excluded these and other nurses from the reimbursement system. It is my further belief that widespread use of gerontological nurse generalists and specialists in a variety of health care delivery settings would realize substantial savings while improving access to health care for the elder. (Please note that although MS recognizes many nurse practitioner roles, it still does not recognize the 'Geriatric' nurse practitioner.)

Although there are multiple areas in the health care delivery system which need renovating, I have chosen to address the use of gerontological nurses in three areas which offer improved assess to health care: community, home care, nursing home services.

Community

The prevalence of chronic illness, particularly among the elderly, has made the financing of health care for acute care ineffectual. These chronic conditions such as hypertension, cerebrovascular accidents, obstructive pulmonary diseases, AIDS, additive and abusive behaviors, arthritis, and a myriad of mental health problems, create an overwhelming health service demand due to the increase in number of elders and the intensity of service used by each elder. Many elders with chronic problems do not have access to appropriate health services unless a serious problem occurs requiring expensive institutional care (NLN, Spring, 1991). Thus, continuity of and access to care are particular problems for elders who have a chronic health problem. The challenge imposed is that care required by these individuals is not constant and often runs a cycle of acute medical and intensive nursing care to chronic medical and nursing care which is primarily supportive and rehabilitative in nature. This quandary could be greatly improved by eliminating barriers restricting nurses, particularly nurse practitioners, from providing care directly to elder consumers. A number of alternative health settings and services provided by nurses across the nation have reduced the demand for expensive institutional care. The following are examples of some of these alternatives, all of these models are appropriate for MS.

One alternative health setting is the "Free standing health clinic" (satellite clinics) which have been in existence for decades providing care to the underprivileged and underserved. MS has a few of these clinics, although the number is dwindling, which are struggling for survival due to reimbursement issues and lack of physician support. Typically these clinics are located in a rural area or a setting where consumers do not have immediate assess to a physician. They are managed by nurse practitioners in collaboration with a sponsoring physician and with the guidance of a protocol when medical management is required. The nurse practitioner's role typically is that of [illegible] Nurse Practitioner has been successfully providing [illegible] residents in the surrounding area for about 12 years. Since she is in rural MS, the majority of her clients are elders. A variation of this clinic is the rural medical clinic whose physician, because of the practice setting, is isolated and has little prospect of attracting another physician due to the income and age level of clients. The nurse practitioner has been invited to join in this practice to manage care particularly for the chronic elder client. The care provided is continuous rather than episodic in nature and includes supportive phone calls and home visits. In MS family nurse practitioners and gerontological nurse practitioners have been invited to join this type of practice and are currently working to develop protocols. This year 2 geriatric nurse practitioner students have been encouraged to return to school and will join a two physician practice in Southeast MS. after graduation. Their primary responsibilities will be to monitor and manage elder clients in the community and in the nursing home adjacent to the hospital.

A third type of setting is the "Block Nurse Clinic". This concept usually employs a nurse practitioner or public health nurse specialist who develops a clinic in a neighborhood. The nurse's prime goal is to personalize an effective method of case management by establishing a neighborhood-based system of care delivery. This model has been evaluated as being effective as a home care alternative (MN) as care provided prevents premature institutionalization of elders and contributes to their quality of life. It also has been evaluated as a cost-effective method of long-term care. (Ebersole & Hess, 1990). Although not called

a Block Nurse Clinic, M.U.W. has two clinics which resemble this concept at Crawford and Artesia, MS. Health care is provided to underserved consumers and monitored by a public health nurse specialist. These clinics are supported by the MS Department of Public Health and have been operationalized for about 10 years (personal communication, D. Harris, 1991).

Another issue appropriate to chronic illness and health setting is the increase in emergency department (ED) visits by elders which is adversely impacting efficient utilization of emergency room services. Multiple studies have been conducted with similar findings including: elders have a higher rate of admission to the hospital and readmission (50%) to the E.D., that the cost of E.D. department expenditures has greatly increased, that the elder needs special services targeted at them for close surveillance and ready access to ancillary health services, that a followup visit is needed for elders with chronic condition (Lowenstein, 1986; Denmen, 1989; Thienlous, 1988; & Bone, 1989). These researchers recommended the development of an interdisciplinary team that would include a nurse with expertise in gerontology to assess, manage, refer, and followup elders. Two effective followup techniques were phone calls, to solicit questions and provide answers about the prescribed treatment and direct elders to appropriate ancillary services; and home visits, to evaluate implementation of the treatment and to clarify and channel problems. Both methods resulted in a significant reduction of admissions to hospitals (Hendrickson, 1989, Ronsdell, 1989). This type of followup care could be initiated as a post ED service. No known hospital in MS is currently adding a gerontic nurse specialist or using either method cited. However, at the request of the ED physicians in a large hospital in Memphis, a graduate student at M.U.W. is implementing a study which focuses on the use of phone calling and home visiting with elders who have chronic congested heart failure.

Home Care

A major trend has been advocated to keep the elder as independent as possible and at home, instead of at the hospital or at the nursing home, even when care is required. The emergence of this trend resulted in part due to governmental restrictions which limit the length of time for hospitalization thus, elders were being discharged to home earlier and sicker. Also, the number of frail elders has increased demanding more nursing home beds which are not available, thus more frail elders are cared for at home. Care being provided for these clients requires advanced technical knowledge due to the sophisticated equipment and procedures now needed in addition to knowledge relevant to the aging process and person. Gerontological nurses are providing care to these clients with very good outcomes. However they are overworked and underpaid. The public must recognize that these nurses are pivotal to providing quality home care as they fulfill the primary role of organizing and coordinating care. The problem persists as restrictive public payment for home care and the lack of private insurance coverage makes services unavailable to many aged who could be sustained in their homes with the aid of dependable and ongoing services. Also, gerontic nurse specialists are not reimbursed for their services. Thus, home health care agencies are unable to enlist their expertise and services.

The point also should be made that many elders are homebound due to age, failing but stable health, or the responsibility of caring for yet another elder. These homebound elders need some assistance with activities of daily living. Most of these services do not require a full-time homemaker or personal attendant, nor do they require a nurse, social worker or physical therapist, or physician. However, a mechanism needs to be developed to get these individuals into some kind of a health networking system so that initially and periodically they can be monitored to maintain an acceptable quality of life.

Additionally, the impact of Alzeheimer's Disease on the elder, family, and community is mandating that health care providers become advocates for programs that focus on those suffering the consequences of these illnesses. Currently assistance to these people is almost non-existent. There is a desperate need for respite beds in acute and long term facilities for the affected patients, in addition to respite help for the homebound caregiver. The later could be in the form of outreach programs, in which a gerontological nurse could coordinate the release of family members for a few hours or a day. Although some hospitals in MS have respite beds they are usually very restricted in number and use. Day Care Centers and vacation camps are two other respite services which can defer or avoid nursing home or hospital admission.

Another solution to help the caregiver has been tried for a few years is the form of an outreach program for elders which is co-funded by a church and the federal government and functioning in 5 counties in central MS. The services that it has provided to the homebound elders are immeasurable. Some examples include: staying with the dependent elder while the independent elder has some respite time, taking the elder grocery shopping or to the doctors, helping with light cleaning, bathing, or cooking, or providing some human companionship. Currently, there is a long waiting list of families in need for this service. More of these and other outreach programs must be developed.

As immediate health care needs are being met, increasing awareness of health status and wellness will occur in the community through nurse coordinated outreach programs, involving community self care. These programs, for elders, will be directed at health promotion. Examples of program activities to be included include peer monitoring programs for blood sugar, blood pressure, and drug side effects, exercise programs, foot care clinics, and health awareness education eg. normal aging and cancer detection. Programs could be developed in collaboration with members of the community and could be housed in community sites, such as churches and congregate eating centers. Participation in peer monitoring and networking programs would not only help with health monitoring but also would promote self-esteem of the volunteers and patients and holds great potential for helping elders to help other elders with the major transitions [illegible] the aging process [illegible] those peer groups [illegible] functions such as [illegible] providing information and referral, telephone reassurance, and make home visits.

Nursing Home Services

The demand for nursing home services is expected to increase by 54% by the year 2000 and by 132% by 2030 (Kramer,et.,al 1985). About 80 to 90% of health problems that occur among nursing home residents can be managed by the Gerontic nurse specialist (Ebersole & Hess, 1990). As an integral member of the nursing home system, gerontological nurse specialists can decrease incidents and accidents, decrease transfers to the acute care system, decrease medication usage, increase functional capacities of residents, and positively influence staff and patient morale.

Summary

The elder population is increasing in numbers and will continue to increase thereby placing an even greater burden on the health care system and the health care dollar. Emphasis, in the past has been placed on curative, institutional and dependence oriented service at exorbitant costs to the taxpayer. The most predominant problem for the elder is chronic illness. These clients require nursing care to manage their illness in the context of daily living. This care can be provided and monitored at the "grass roots" level that is home, community, or nursing home facility. Nearly 3/4's of Americans (73%) consider it

realistic to keep more senior citizens in their homes. Essentially 4 in 5 senior citizens regard expanded home health care as a realistic alternative (Hart, 1990).

I believe that elders are not well served in the present health care system and that nurses, especially gerontological generalists and specialists can do much to improve this dilemma. In addition, I believe that the public is not fully familiar with health care options such as reliance on nurses instead of physicians for basic health care and home based health care. Nurses are fully licensed and have been granted credentials by professional organizations to provide the services within the scope of the nursing practice act.

In all settings offering services to elders, the gerontic nurse specialist practices according to explicit criteria and standards as set forth by the ANA, and is certified to:

Take histories
Perform physical and psychosocial evaluations
*Moniter and manage the common acute, episodic, and chronic stable health problems of the elderly client.
*Prescribe medication in states that include prescribing as a part of the expanding practice act.
Collaborate with the client to set goals
Do case coordination and management
Council with individuals and families
Educate to promote compliance and understanding
Promote preventive care
Collaborate with other health disciplines
*Some of these activities overlap the physician's medical management and in these cases decisions are guided by protocols that have been developed by the gerontological nurse and collaborating physician.

These services should be eligible for third-party reimbursement.

I believe that the federal government should consider the following goals:

1. Encourage a long term care insurance program to maintain elderly people in their homes and communities. Consider a Medicare Part C, revise the Med IRA, or develop some type of long [illegible] fund. Those receiving benefits should participate in the costs. Program management should be administered by the state. The program could build upon the long-term care systems already in place, significantly decreasing start up costs and promoting integration of existing programs. Each state could develop an ad hoc committee to develop and define parameters of eligibility for elders, sites, and services with a plan for outcome evaluation (Personal communication, A. Wilson, 1991).

2. Support tax credits to offset dependent care expenses incurred by families who care for dependent elders at home. This action could encourage more families to assume this responsibility and would favorably influence the quality of life for the elder.

3. Clarify and strengthen the education system for nursing by securing increased appropriations for the Nurse Education Act for undergraduate traineeships, advanced nurse training, nurse practitioners, student loans and special projects. Financial incentives also are needed for education and retention of faculty. Support legislation that would provide educational opportunities for individuals who will deliver care to the vulnerable and underserved (rural and urban) areas (ANA's Strategic Plan, Fiscal Year 1991). These actions would serve as incentives to recruit students and faculty to nursing who would have a special focus on care of the elder.

4. Mandate that a nurse be appointed to committees involved in making rules and regulations that affect the health care system. This action would greatly strengthen the interdisciplinary approach mandated in care of the elder.

5. Fund an Ad Hoc Committee to develop a resource manual outlining governmental services available, providers of care, eligibility, and how outcomes were monitored. Currently there exists duplication of services with no clear sense of what resources, (federal, state, and community) are available. This situation allows for misuse of services and appropriated money.

6. Develop and/or support amendments to all Federal insurance programs (Federal Employee Health Benefits Program, Employee Retirement Income Security Act, Medicare/Medicaid, Civilian Health and Medical Programs of the Uniformed Services) and health care initiatives that would allow for family care of dependent elders, disease prevention and health promotion programs, and reimbursement of nurses for their services. These actions would alleviate the mental, physical, and financial burdens of 'at home' caregivers; deter chronic illness; decrease exacerbations of acute phases and better control existing chronic illnesses; and further stimulate the retention of nurses to remain involved with national health issues such as providing care to elders.

7. Develop and/or support nursing home legislation that would strengthen Medicaid waver language, mandate RN coverage for 24 hours, and promote gerontological specialists. This action would strengthen the implantation of OBRA 90 for better quality of life for residents of nursing homes.

8. Fund nursing research focused on care of elders. This action would stimulate improvement of existing interventions and development of innovative approaches addressing issues related to the elder citizen. Further, it would promote the inclusion of nurse researcher participation in existing advisory boards for grants and service awards.

TESTIMONY BEFORE THE SUBCOMMITTEE ON AGING
OF THE U.S. SENATE LABOR AND HUMAN RESOURCES
COMMITTEE FIELD HEARING ON
"ACCESS TO HEALTH CARE FOR THE ELDERLY"

DELIVERED BY

MARTHA CAROLE WHITE, EXECUTIVE DIRECTOR,
THE MISSISSIPPI HEALTH CARE ASSOCIATION
MAY 1, 1991
CIVIC AUDITORIUM, CLARKSDALE, MISSISSIPPI

Preface

The following statements focus on long term nursing facility care of the elderly, and barriers to the access of care in this particular field of specialization. It is presented by the Mississippi Health Care Association, a professional association of nursing facilities whose membership comprises in excess of 13,000 nursing facility beds in the state, which is approximately 75% of all nursing facilities in the state of Mississippi.

Introduction

The face of long Term Care for the elderly is a unique one. The continuum of long term care involves the specialties of physician, nursing, hospital, and various therapy services. It is the combining of these acute care services into a unified, long term group-living arrangement that is the challenge and responsibility of the long term care nursing facility specialty.

To this medically oriented mix must be added the appropriate amount of physical and mental activity, social work services and counseling in matters of life and death, proper nutrition, and constant involvement in the preservation of the individual and legal "rights" of all residents.

Because of the uniqueness of this specialty, long term care providers and recipients have their special concerns and ideas about what constitutes "barriers" to this care.

Barrier Number One

The first "barrier" to be cited is the reluctance of government and health care advocates to recognize and acknowledge the difference between acute care and long term nursing facility care.

As testimony to this failure to recognize and acknowledge the difference, one is directed to consider the vast Federal Medicare program which is, and always has been, constructed, reconstructed and administered with an expressed bias toward acute care.

Our experience has demonstrated that this fact confounds most elderly people. Even state lawmakers and regulators have, in the past, demonstrated a "say it isn't so" attitude, when confronted with the realities of this truth.

The reason for this lack of understanding is that since the costs of long term, 24 hour, all-encompassing nursing facility services are the most "catastrophic health care cost" of them all, it does seem amazing that no long term care, and only a very, very limited nursing facility benefit is available to the elderly through the Medicare program.

It is worth repeating that many elderly people do not

understand this fact at all. The average, and even above average citizen, does not begin to be able to understand why his local nursing facility may not participate in the Medicare program. It is impossible for this citizen to understand the Medicare program's maize of facility requirements, patient requirements, the uncertain payment system, and the extremely limited benefits allowed to the patient.

When Medicare nursing facility benefits are allowed to the qualifying patient, in a Medicare certified facility, both the "benefits" and the patient's physical condition must mimic "acute" care, a requirement which is in itself a solid testimony to the "barrier" we cite as the reluctance to recognize and acknowledge the difference between acute care and long term nursing facility care.

Barrier Number Two

Another related barrier created within the Medicare program is the requirement that a person seeking to qualify for the Medicare skilled nursing facility benefit must first have spent at least three days in a hospital.

Proponents of the hospital requirement argue that it serves a gatekeeper function in order to prevent unnecessary admissions to nursing facilities. Unfortunately, to the extent that this function is effective, the three day stay requirement serves as a barrier to skilled nursing facility services. At the same time, it also facilitates unnecessary hospital stays for persons only in need of the level of service provided by a skilled nursing facility.

Actual data is available to estimate the effect of the change in policy for 1989, the year that the three day stay requirement was not in effect due to enactment of the Medicare Catastrophic Coverage Act. That year, admissions to nursing facilities did increase by approximately 150,000 due to the provision's elimination. The cost to the nursing home part of the Medicare program increased by about $250 million for 1989. However, it is estimated that about 61,500 of all Medicare skilled nursing

facility admissions during 1989 avoided unnecessary hospital stays, which resulted in a savings of about $500 million in Medicare hospital costs. The net result is that the elimination of the three day requirement reduced Medicare costs by approximately $250 million during the life of the Medicare Catastrophic Coverage Act.

Barrier Number Three

A third barrier to long term nursing facility care for the elderly can be identified as being attributable to the often inadequate reimbursement qualities of Medicaid programs in general.

While the positive impact of the Medicaid program on all ages and conditions of its recipients in Mississippi can not be overstated, the fact remains that at a time when the government (both state and federal), consumers, regulators, and nursing facility providers themselves are demanding "quality" in the delivery of services, Medicaid reimbursement systems are most often constructed within the parameters of "cost containment", rather than adequate payment for demanded services. This drive for "cost containment" can result in the following situations which negatively impact that sought after consistency of "quality", and have the consequences of imposing additional barriers to the public who is expecting to be served by the local nursing facility:

* Wage disparity between nursing facilities and hospitals...in hospital nurses are on an higher wage scale than are nursing facility nurses

* Staffing problems...the unavailability of licensed nurses, physicians, and other required specialties, particularly in the rural areas, making it difficult, if not impossible, for some facilities to maintain an increasingly high census of patients requiring "heavy care" or constant 24-hour supervision

* High staff turn-over...high stress, low pay makes the local fast food outlet or the local factory a much more attractive place of employment for many people...more nursing facility staffing problems result

* Burdensome regulations for the facility...regulations which have more to do with paper compliance than the happiness, satisfaction and well-being of the nursing facility resident

* The general atmosphere of uncertainty within the long term nursing facility provider system, due to massive Congressional changes to the nursing facility delivery system (OBRA 1987), implemented largely without written regulations and timely guidance from federal regulatory agencies

To this last point, it can be added that this provider uncertainty, with regard to both regulatory and reimbursement issues, has found expression in provider support for the development of standardized and quantifiable criteria whereby any proposed payment system can be held accountable for services rendered. This accountability would take the form of criteria to be utilized by the Health Care Financing Administration in the approval of state Medicaid reimbursement plans. Hopefully, this type of accountability would have a stabilizing effect on the long term care delivery system, thereby minimizing the barriers cited which have a negative impact on the availability of nursing facility services for those elderly in need of those services.

Summary

Identifying barriers to long term nursing facility care is not difficult, since these barriers largely grow out of government's quest to balance the availability of health care services for the elderly with the availability of resources to pay for this care.

Long term care is a unique service, and cannot appropriately be treated the same as acute care. The Medicare and Medicaid programs need restructuring in order to improve accessibility for the elderly person needing care, and improve the payment system for providers who specialize in this care.

Conclusion

Because the existence of barriers to long term health care for the elderly appears to be largely bound up with various issues relating to finances, long term care providers suggest that the following principles be considered:

CONTINUUM OF CARE

The nation's long term care financing system should provide access to an appropriate level of care along the entire continuum

so that patient need and efficient use of resources -- not availability of benefits -- determines care setting.

CONSUMER EMPOWERMENT

Consumers -- the elderly and their families -- should have as much as is practical to say about the setting of care and who provides it.

PAYMENT FOR QUALITY CARE

Our long term care payment system should encourage and reward quality care.

ENCOURAGEMENT OF FAMILY SUPPORT

Public resources should supplement -- not supplant personal and family efforts to provide and pay for long term care.

PRIVATE/PUBLIC PARTNERSHIP

The private sector should be encouraged to fulfill the largest possible role in the financing of long term care.

FEDERAL/STATE ROLES

There should be a federal and state partnership of administration, enforcement and funding that is designed to eliminate conflicts.

[illegible]

[illegible] through a dedicated, actuarially-sound trust fund that provides both political and fiscal stability.

SIMPLICITY

Our long term care system should maximize the use of public funds on patient care by seeking administrative simplicity and economy.

These principles could be used to evaluate both the elements of sweeping reform advocated by some, and the incremental system changes which might be more likely to occur, given today's climate of budgetary limitations. The result of the successful use of guiding principles would be the same, however, and that result would be the minimization of barriers to long term health care for the elderly.

ACCESS TO HEALTH CARE FOR THE ELDERLY..... BARRIERS TO BREECH

Presented before Senate Subcommittee on Aging
Senate Labor and Human Resources Committee
Field Hearing, Civic Auditorium, Clarksdale, MS
9:00 a.m., Wednesday, May 1, 1991

Witness: Clifford L. Johnson, Jr., FACHE, Executive Director
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Senator Cochran, members of the Subcommittee on Aging: It is a pleasure for me to have this opportunity to address you today to discuss barriers to the access of health care for the elderly. My name is Clifford L. Johnson. I am the Executive Director of the Northwest Mississippi Regional Medical Center in Clarksdale, Mississippi.

I would first like to tell you about the health care delivery system in Coahoma County. This hospital opened in 1952 as a 100-bed general, acute care hospital. We now operate 194 beds. Our most significant growth, however, lies not in doubling the number of hospital beds but in the expansion of services we provide. We have a very highly trained physician staff of 44 doctors, 50% of whom are Board Certified specialists. We have an employee staff of 550 employees, and our annual budget exceeds $40 million.

Typical services provided here are:

Laparoscopic Surgery
General Surgery
Orthopedic Surgery
Ophthalmology
Urology
Obstetrics and Gynecology
Cardiology
Pediatrics
Internal Medicine
Family Practice
Pathology
Anesthesiology
Radiology and Nuclear Medicine

We provide CT scanning, nuclear medicine, ultrasound, and most all radiological procedures. We do echocardiology, pulmonary function, stress testing, and most cardiopulmonary and laboratory procedures.

In other words, this hospital is providing care to patients in a seven-county area of the Mississippi Delta with facilities and physician expertise that are commensurate with many of our urban counterparts. We function as a regional referral center, though at the present time we are not recognized as such by HCFA due to our failure to meet some of the case mix indices.

In addition to our role as a major health care provider, we are an absolute key to the economic viability of Coahoma County, Mississippi, with its 31,000 citizens. If this hospital were not to prevail..... if the doctors dwindle away, and the Medical Center had to close, the elderly of this area would be virtually abandoned and extremely hard pressed to access any type of health care at all.

So this morning, let us consider our present position as a rural health care provider. On the positive side, in reducing barriers to access, I can report that in this community most physicians treat Medicare patients. Additionally, Medicare recipients are promptly accepted for care at our hospital without regard to race, color, or ability to pay. Our Emergency Department is

staffed 24 hours a day with fulltime physician coverage and our ambulances respond at a moment's notice.

In December our hospital purchased a six-county home health agency in an effort to provide additional services to the people we serve. There is a problem with transportation in our community, and the home health agency relieves this situation to some degree in that we take health care to the patients. There are many towns within the six-county area we serve that are in desperate need of health care, and we feel this is an improvement.

Our hospital is also involved in an Emergency Response Program, called LIFELINE. We have just expanded this program and will soon have over 125 units in this county. This response center allows the aged or handicapped person to summons help instantly. The majority of persons using LIFELINE are aged individuals.

Future prospects concerning ready access to health care are quite different, however. In my estimation, the real and present danger in Clarksdale, and in other rural areas of our state, is the complete failure of doctors and hospitals to survive economically by reason of carrying the huge financial losses incurred in caring for the elderly and the indigent. This is a major barrier. Several factors relative to Medicare reimbursement and HCFA regulations are at the root cause.

URBANS VERSUS RURALS

The hospitals and physicians are held hostage by HCFA policies that have established payment differentials between urban providers and rural providers. There may have been some justification in the past for this dual system, but I can tell you from experience it is not valid now.

One of the most crippling economic blows to our hospital lies in the inequities of the urban/rural differential. One good example of this that I can site is the Disproportionate Share payment system. Disproportionate Share payments are made to hospitals based on the level of low-income patients treated, which includes many of the elderly. Currently rural and urban hospitals are paid under different methodologies, which heavily favor urbans.

[illegible] treated.

Urban hospital payments, on the other hand, are based on the TOTAL PERCENTAGE of low-income patients treated. Furthermore, legislation has been passed to increase the components of the formula used to calculate disproportionate share payments for urban facilities in each of the next five years. But the rural rate is to remain fixed at the current 4% level. This is blatantly unfair.

In our facility, sufficient low-income patients are treated to bring our add-on payment to approximately 22% (not 4%). If our disproportionate share were calculated as the urban hospitals are, we would receive $1,764,000 annually. But since that is not the case, we must leave $1,643,000 on the table. I cannot begin to tell you what $1 million means to a hospital such as ours.

Disproportionate share, by its very nature, is a payment system designed to compensate hospitals treating unusually large numbers of low-income patients. Why cannot the formula be the same? Such discriminatory practices are putting rural hospitals in an untenable position. We are held hostage by federal guidelines that expect us to refuse no one service because of inability to pay; yet we are penalized solely because we exist in the Mississippi Delta instead of Jackson, MS, or Memphis, TN. Help us correct this situation!

Insofar as Medicare reimbursement to our hospital is concerned, the DRG prospective payment system discounts approximately 50% - 60% of charges. And I remind you again, that we are 60% Medicare by patient mix. I have enclosed an exhibit illustrating the fact that if the rural hospital in Clarksdale had been treated equally with the urban hospitals during FY 1991, the NwMRMC would receive an additional $769.35 per discharge - or approximately $2,104,942.

It would appear that there is some sort of federal squeeze play underway to make it economically impossible to practice medicine in rural Mississippi and therefore shut us down. It is imperative that someone thinks this situation through to the grim consequences that will surely follow if the government continues its present approach to Medicare reimbursement with differing payment scales all over this country. No business can overcome such duress.

When you couple the disparity in payments between urban and rural areas with the fact that often there is a higher concentration of indigent patients in rural communities, it compounds the problem. Considering the desperate economic climate of the Mississippi Delta and the dire predictions coming out of Washington, I fear that health care access to the elderly, to indigents, and even to privately insured patients is going to be severly threatened. Rural hospitals simply cannot survive the crunch.

THE PHYSICIANS' PLIGHT

The whole cycle of health care begins and ends with doctors. The success of the Medicare program rests in the willingness of physicians to participate in it. We have 44 physicians on our staff, and I am so appreciative of their dedicated efforts on behalf of our patients. As bad as the hospital's plight is in fighting the inequities of urban/rural reimbursement, I believe the physicians are penalized even more. Physicians here are increasingly questioning if they can afford to see Medicare patients at all. Again, discounts of 50% - 60% of charges are commonplace. Physicians have totally lost confidence in our federally funded programs. (In my documentation I have provided comments from some of our medical staff members which I urge you to read. They have stated their case in alarming terms, and we must not turn a deaf ear.)

Physicians point out that even though the government claims to have figures which in the past have justified the disparity between urban and rural reimbursement schedules; our physicians working in the trenches do not see any financial advantages whatsoever to practicing in rural areas. More to the point, why should they practice here, when one hour to the north in Memphis, Tennessee, physicians are receiving three times the reimbursement for seeing Medicare patients as Clarksdale physicians. They tell me that it is their experience that they not only have to pay the same for supplies, personnel and services, but in many instances are required to pay a higher fee due to Clarkdale's remote distance from major urban service centers.

This holds true for the hospital as well. We are constantly comparing what we have to pay in the Delta for services, personnel, and goods to what urbans are paying. And I can tell you that in almost every instance we are paying the same or perhaps more than those providers in urban areas.

The only hope that we see for improved reimbursement to physicians in this area is to equalize reimbursement levels between urban and rural providers. However, federal sources indicate we will probably see only a reduction in urban reimbursement and the rural rate will be kept at the same level. This is no answer for us. There must be a redistribution of total health dollars along equitable lines based on reasonable charges for services, not the cost of eggs in New York City.

By 1995, 13 of our 44 physicians will have achieved or passed the age of 65. That's roughly one third of our Medical Staff. Economic constraints are causing many of our most highly qualified physicians to work week-ends in various Emergency Rooms about the area in order to supplement their incomes.... a direct result of inadequate federal reimbursement for services rendered. I ask you: How are we to recruit physicians for the future under these circumstances? What young doctor is going to choose rural Mississippi when he can hang his shingle anywhere else and be better off financially. Failure to recruit future healthcare professionals to the rural South is a major threat to access of medical care for the elderly and everyone else.

I must mention the need for some sort of transportation system that would provide a means for the elderly and poor to keep doctors' appointments and access hospital services. This has been documented many times before, yet we seem no closer to a solution. It certainly is needful.

I also need to comment that I feel Medicare has made a step in the right direction to begin paying for screening procedures such as mammograms and Pap smears. I endorse any efforts to underwrite preventive measures which lead to early detection and diagnosis of cancer and other dread diseases. This is certainly a more cost-effective approach and will surely result in a better quality of life for our seniors.

Probably the most complicated and costly medical need for the elderly is the matter of long term care. Medicare reimbursement is very limited at this time, but clearly the elderly live in fear of how to pay for long term care. The typical yearly cost (mostly out of pocket) is $20,000 for a nursing home bed, and the average stay is two years. This is a tough issue with no easy answers.

CRACKS IN THE SYSTEM

So where are we? We know the older population is multiplying rapidly. By the end of this century there will be some 31 million people in the 65-and-over category. By the time the entire Baby Boom generation retires, there will be some 55 million Americans over 65, comprising about 18% of the population.

We know the expanded years are attributal to advances in medical technology which have come to the fore since Medicare was enacted in 1965... innovations like antibiotics, hemodialysis, pace makers, cardiac bypasses, hip replacements.

Yes, we are well aware of the "greying of America", yet in recent years the nation's birthrate has sharpely declined. We know there are millions of homeless Americans who are not in the social security system. We know that thousands of others are unemployed, or part of the drug culture, or otherwise impaired and not part of productive society.

What I am saying is that there are fewer people in the work force to pick up the tab for the biggest Medicare generation yet experienced in this country. How do we pay for health care for the elderly generations to come? Who has the responsibility to determine when the healthcare provided is adequate - or appropriate? Something has got to give.

Congress made a promise to older Americans in 1965 when it passed the Older American Act. The promise, in part, was that "the best possible physical and mental health which science could make available without regard to economic status" (would be extended to them). This promise has certainly been kept. But you must realize that it is the physician and hospital providers who have KEPT the promise by bearing the brunt of uncompensated care. The Congress of 1965 could not possibly have foreseen 1991 costs. As a hospital administrator, I am beginning to wonder if this promise can continue to be kept.

It has been said that "without a vision, the people perish." Senator Cochran, I ask you, "What is America's vision?" I respectfully submit to you that high on the national agenda must be the nation's healthcare delivery system, particularly as it affects rural physicians and hospitals. Unless Congress confronts this issue now with some tough, objective action to equalize Medicare reimbursement to physician and healthcare providers that there will be a healthcare crisis in this country such as never before experienced in the history of this nation.

It is my hope that we will be responsible leaders.... that we will plan well for our elderly now and in the years to come. We're running out of time in the Mississippi Delta. If we are to preserve any vestage of quality healthcare, we must have economic relief and have it soon.

Thank you.

NORTHWEST MISSISSIPPI REGIONAL MEDICAL CENTER, CLARKSDALE,MISSISSIPPI

Subcommittee on Aging
Wednesday, May 1, 1991

INEQUITIES IN URBAN/RURAL REIMBURSEMENT

A) Disproportionate Share
B) Labor & Non-Labor Related Factors and Wage Index
C) Comparison of Cost - Urban VS Rural

Examples of Medicare Reimbursement to Physicians/Texas vs Mississippi

Code #	Amount Approved Medicare Texas	Amount Approved Medicare Mississippi
90270	48.50	22.30
90220	96.90	57.60
90250	32.30	22.30
90935	93.80	60.90
M0945WI	201.00	156.60

Disproportionate share payments are added payments that are made to a hospital that treats a disproportionate share of low income patients. Low income patients are those patients who qualify for Medicaid and those patients who qualify for Medicare who also draw SSI benefits.

Two percentages are involved with disproportionate share payments. The first is the percentage of Medicaid patients treated added with the percentage of Medicare patients who draw SSI. This total is the qualifying percentage. Second is the add-on percentage which is the percentage of increase in payments received by hospitals.

Currently there are two classifications of hospitals in the disproportionate share system: Urban and Rural

To receive disproportionate share funds an Urban hospital must have a minimum qualifying percentage of 15%. With a qualifying percentage of 15% an Urban hospital would receive an add-on percentage of 2.5%. At a qualifying percentage of 20.2% the add-on percentage has increased to 5.62%. Thereafter, the following formula is used to calculate the add-on percentage:

(Qualifying percentage - 20.2%) X .65 + 5.62%

The maximum add-on percentage for an Urban hospital is limited only by it's qualifying percentage.

To receive disproportionate share funds a Rural hospital must have a minimum qualifying percentage of 30%. With this qualifying percentage the hospital would receive an add-on percentage of 4%. This is also the maximum percentage that a Rural hospital can receive.

In Summary:

Rural hospitals must have a qualifying percentage of 30% to qualify for a 4% add-on payment

Urban hospitals need only have a 40% qualifying percentage to qualify for a 18.5% add-on payment

Also legislation has passed to increase the components of the above formula used to calculate disproportionate share payments [illegible] however the rural rate is to remain fixed at the current 4% level.

For fiscal year 1989 the Northwest Mississippi Regional Medical Center received $221.000 as a Disproportionate Share Adjustment. This is the 4% add-on to the DRG payments.

If the NWMRMC had been receiving the same percentage as an urban facility with the same percentage of low-income patients as admitted here, the amount of the Disproportionate Share adjustment would have been $1,764,000.

Prospective payment rates are made up of three factors: Labor Related Factor, Non-Labor related Factor, and the Wage Index. Separate labor and Non-labor rates are set for Urban and Rural hospitals. Each Urban area has it's own wage index, however, Rural hospitals are grouped together by state.

The following is a list of the discrepancies in the wage index for Urban and Rural areas:

Memphis, TN	.9099
Jackson, MS	.9097
Biloxi-Gulfport, MS	.8090
All Rural MS Hospitals	.6993

The breakdown of the two other components of the prospective payment rate follow:

LARGE URBAN

LABOR RELATED	NON-LABOR RELATED
2,531.54	1,042.97

OTHER URBAN

LABOR RELATED	NON-LABOR RELATED
2,491.49	1,026.46

RURAL

LABOR RELATED	NON-LABOR RELATED
2,487.04	784.43

If the Rural hospital in Clarksdale, MS. had been treated equally with the Urban hospitals during FY 1991. the NWMRMC would receive an additional $769.35 per discharge or approximately $2,104,942.

COMPARISON OF COST - URBAN VS RURAL

DESCRIPTION	OUR COST	URBAN HOSPITAL
Medtronic #5985 Pacemaker	$ 3,700.00	$ 2,800.00
Medtronic #4011-58 Lead	650.00	585.00
DuPont Film 14 x 17	146.29/bx	140.45/bx
Disp. Lap Pack J&J #1259	12.40/ea	10.19/ea
IV Placement Units Jelco	1.33/ea	.60/ea
Lab Reagents:		
[illegible]	[illegible]	[illegible]
Abbott Phenbarbital Kit	305.00/ea	245.00/ea
Syringe, 33cc w/needle	5.39/c	5.17/c
4x4 Gauze,Sterile 12ply 10pkg	.52/pkg	.38/pkg
D5/LR, 1000ml - bag	.96/bag	.91/bag
8 1/2 x 11 white 20# bond	3.33/rm	2.75/rm
Surgeon Gloves	.40/pr	.36/pr

NORTHWEST MISSISSIPPI REGIONAL MEDICAL CENTER, CLARKSDALE,MISSISSIPPI

Subcommittee on Aging
Wednesday, May 1, 1991

Physicians' Comments

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April 16, 1991

APR 19 1991

Mr. Clifford L. Johnson, Jr., FACHE
Executive Director
Northwest Mississippi Regional Medical Center
Post Office Box 1218
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Re: U.S. Senate Subcommittee Hearing on "Barriers to Accessing Healthcare in the Elderly".

Dear Mr. Johnson:

I read with interest your memo to the medical staff regarding the above hearing. From my recent letter, I believe you know my thoughts, however I would like to send you something in writing that focuses on this problem and not on others that are more of a local nature.

First of all, I would definitely agree with you that considering the economic climate here in the Mississippi Delta and predicting what may be ahead for physician reimbursement based on current reports out of Washington, health access to the elderly patients, indigents, and even possibly even to privately insured patients, may be significantly hindered in the future due to a lack of physicians.

I would like to re-emphasize my concern that even though the government claims they have figures which in the past have justified the disparity between urban and rural reimbursement to health care providers, we, the individual health care providers on the front line do not see any financial benefit whatsoever for practicing in rural areas. It has been my first hand experience over the last several years that we not only have to pay the same for our supplies, personnel, and services, but in many instances are required to pay a higher fee simply to attract good personnel and to keep highly technological equipment in operating condition because it is being remote from major urban centers. I am constantly comparing what we have to pay in this area for our services, personnel, and goods to what others are paying and I can tell you that in almost every instance when I inquire, we are paying the same or perhaps more than those in urban areas. When you couple this disparity in payment between urban and rural areas with the fact that there is, in many instances a higher concentration of indigent patients in the average private practitioner's practice in rural areas than in urban, it compounds the problem. Our population in the Mississippi Delta area is doing two things as we can see it today, aging and becoming more indigent. We do not have an influx of young people, in fact, if the truth is known, the younger people are probably leaving this area. There is no significant improvement in the job market or in industry in this area, and when you consider why the Mississippi Delta exists and what its land is most profitable for doing, you have to understand that this will probably never be significantly an industrial area. Based on these facts, the outlook here under current governmental policies and procedures is very bleak for the private physician practitioner. In order to have a profitable practice even marginally in todays financial scenario, the physician must have a low population of indigent and Medicare reimbursed patients and the practice must be exposed to a considerable number of younger, privately insured patients, as well as the elderly patient insured by governmental programs. This situation simply does not exist in the Mississippi Delta.

From what I can see from talking with colleagues both in this city and in other areas of the Delta, physicians have totally lost any confidence whatsoever in our federally funded programs and we see one thing, that is a dwindling reimbursement that ignores the fact that we are unfairly treated in rural areas. We have been promised pie in the sky with the resource based relative value scale and from all predictions that I can read now, at best, primary care providers may see a 10% increase in their primary care

services. When you take a practice such as mine and Dr. Yates' where we a considerable number of procedures that are also considered surgical, will probably see a significant drop in those procedures, which wi obviously nullify any improvement in the primary care increase that might see. Our only hope for seeing any improvement in reimbursement this area is if there is some equalization in rural and urban reimburseme levels. However, from what we have seen from the government recently, will probably see a reduction in urban reimbursement and the rur reimbursement kept the same. As an example, we had a physician whom y know well, leave here recently and move to the Houston area. After he w in Houston, Tx for some time, he phoned Dr. Yates and myself to inquire h things were going and informed us that he could not believe it, but w receiving approximately $56.00 for a routine daily hospital visit in t Houston area when he received approximately $26 or $27.00 for the sa service he was delivering here in Clarksdale. His comment to us at th time was that he was paying the same, or less for his housing, the same a the grocery store and in other merchants in his area, and that his practic costs were not any higher in his estimation in the Houston area than the were in the Clarksdale area. We have heard this time and time again fr other physicians that we meet when we go away to medical meetings in urba areas.

When you consider that the average board certified physician has spent total of twenty-four years in education from the first grade on up, i should be a surprise to anyone in America that this person expects to b financially secure in his or her lifetime. This is especially true whe you consider the commitment in time away from the family and the commitmen to being available night and day that the physician has to make. I ca tell you that after spending eight years in practice in this area, tryin my best to see the insured and the uninsured patients, and to give al patients equal care and the best of care, I personally am very discourage over the fact that my financial situation is hardly better now than it wa on my arrival in Clarksdale in 1983. If I should decide to leave thi area, it will not be without considerable deliberation, because I feel have made a commitment to my patients and to this area. However, I ca also tell you that as each day passes, and as I read each new article abou the way Congress is handling Medicare budget cuts and physician reimbursement, I am more and more convinced that I must seek a medical practice in an area where I can serve a younger, more well-insured population. I am not opposed to cost containment in the field of health care, but as a single practitioner, I cannot bear the burden of decreased reimbursements that I have had to bear over the last eight years. It is simply not possible and no matter how much I would hate to leave this area, or how much I would hate to tell my patients that they all had to find a new doctor, I still have my own welfare and the welfare of my family to be concerned about. I can assure you that in the end the decision will rest on what is best for my family.

Thank you for inviting my comments. I certainly hope that they will assist you in this hearing. If I can be of any further help in any way, please do not hesitate to call.

Sincerely,

Timothy H. Lamb, D. O.

Pat S. Burke, M.D.
Medical Arts Building
Evelyn Street
Clarksdale, MS 38614

Thank you for asking me for my comments regarding the elderly and barriers to good health care. The elderly people of this country believe that if they have Medicare it will pay for everything that a doctor offers. Doctors are trying their best to give good-quality medical care, and in order to do so they need to have money. Trying to convince some of the elderly people that Medicare will NOT pay is hard to do; and the ones that do understand refuse to sign a form stating that they will pay when they feel they are already paying a high price for Medicare coverage. Most of the elderly are on limited incomes; and many have minimal education and really do not understand all the rules and regulations that are involved with Medicare.

Listed below are several examples of what doctors are facing:

1. Chest x-rays are not reimbursed as a screening exam. Chest x-rays are needed on people yearly due to the increase rise of lung cancer and cancer in general. Most of these patients are 60+ and have been cigarette smokers for many, many years and have either developed Emphysema, Chronic Obstructive Pulmonary Disease and/or Cancer. These elderly patients are on limited incomes and most cannot afford to pay for those services that Medicare does not reimburse. A simply chest x-ray picks up more pathology for the money than most other diagnostic tests.

2. EKG's. This is a necessary test in the diagnosis of heart disease, and no information can be determined unless the EKG is done while the patient is in distress. Most of the patients have some prior heart disease and need follow-up EKG's on a yearly basis to ensure good patient care.

3. Lab work in the doctors' offices. Having a patient in the office who has diabetes that not uncontrolled due to diet, medication, etc., and having to wait for lab results from other reference laboratories for 3 - 6 hours can be quite irritating to the patient, the doctor and the staff. Office testing is essential to timely diagnosis and treatment. Prompt lab work is needed to determine the cause of the patient's illness and to determine proper medication. It would certainly reduce one of the "barriers to health care" if the patient could come to one place, be tested, and learn the results of the studies within minutes instead of having to send him several places and still not know anything about their illness until later in the day or even the next day.

It is unjust that people in California and New York pay the same Social Security percentages as people in the State of Mississippi; but services reimbursed by Medicare are radically different..... in fact, about 3 - 4 times less.

Reimbursement to physicians in the Mississippi Delta is less than anywhere else in Mississippi. This is not right. It costs as much to live in the Mississippi Delta as it does on the Coast or Jackson. Therefore, why penalize the doctors in Mississippi for having low charges back in 1965 when Medicare was introduced? Physicians should be treated equally.

The American Hosptial Association says that people with cardiac arrhythimas on prescriptions need to have a Holter Monitor exam 3 - 6 weeks after a change in dosage or a change in medications in order to control the rhythm. Medicare will only pay for a Holter Monitor every 6 months. Why should doctors not get paid for giving the elderly the best care possible?

This is just the tip of the iceberg. These are only a few of the problems physicians must contend with daily.

ROBERT RAY MCGEE, M.D., F.A.C.P.
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CLARKSDALE, MS 38614

TO: CLIFFORD L. JOHNSON, JR., FACHE
EXECUTIVE DIRECTOR
NORTHWEST MISSISSIPPI REGIONAL MEDICAL CENTER
CLARKSDALE, MS 38614

RE: BARRIERS TO HEALTH CARE FOR THE ELDERLY

Adequate and accessible primary care is said to be a major problem for patients generally and Medicare patients particularly.

I run a primary care office. About 50% of my time and my employee's time, is devoted to paperwork. My practice is heavily weighted toward Medicare. Medicare accounts for an excessive proportion of this paperwork.

Medicare pays approximately 50% of my usual and customary fee. I accept assignment on all patients. Medicare limits my total fee to somewhat less than 60% of what I charge other patients and my basic fees are quite modest. Therefore, I am discouraging further new Medicare patients.

There is a grave inequity in Medicare claims processing between high paying specialties and primary care specialists. For instance, an ophthalmologist does a cataract operation. I have to do about 60 office visits to be paid what he is paid for one operation. I can see about four of these patients in the time he does one operation. So his hourly rate is 15 times mine. But worse is that I have to fill out 60 claim forms to equal what he collects with one form.

This is just one small example of the inequities and frustrations that permeate the Medicare system as seen through the eyes of a primary care physician in the Mississippi Delta.

NORTHWEST MISSISSIPPI REGIONAL MEDICAL CENTER
POST OFFICE BOX 1218 • CLARKSDALE, MS 38614 • (601) 627-3211

April 19, 1991

Mr. Clifford L. Johnson, Jr.
Executive Director
Northwest Mississippi Regional Medical Center
Clarksdale, Mississippi 38614

Dear Mr. Johnson:

This is in response to your letter of April 15, 1991, relating to the U.S. Senate Subcommittee hearings. Over the last two years and especially extending into the current year, there has been a noticable decrease in remuneration of those services performed for medicare patients. This influence on the physicians in this area is magnified because of the large number of such patients. Other factors such as a large medicaid constituency as well as a significant portion of patients who are charity, produces a certain degree of sensitivity to any changes in remuneration.

In attempting to recruit other physicians or technicians we are in many ways unable to compete because of the differences in salaries and fringe benefits. When these people can receive better salaries elsewhere, sometimes up to two to three times as much, as well as other more attractive incentives, it is extremely difficult to convince them to practice here or in similar locations.

I also question the methodology in arriving at the data utilized for determining geographical cost indices and wonder whether these were adequate, dated or improperly weighted as to value or priority given to certain data. I am also concerned whether the information regarding the factors involved in the practice and delivery of medical care was appropriately based.

At any rate, should the trend continue, there may well be areas in this country and in particular the Delta of Mississippi, which will be extremely short of adequate physician coverage.

Respectfully,

William S. Pollard, M.D.

Anne E. Brooks, D.O.
Tutwiler Medical Clinic
Tutwiler, MS 38963

With only 3 physicians remaining in Tallahatchie county, and only one in the east side, the question is raised about recruitment. There are several items to consider.

1. Health Corps physicians are hard to find, as most have paid back their scholarship time.
2. Physicians need enough patients to support a practice; this implies a fairly high percentage of patients who can pay or who have third party payers that do not demand a huge deductible.
3. Physicians in many cases are reluctant to provide care to large numbers of Medicaid and Medicare patients because the reimbursement is so poor.
4. There are a number of small communities in the county. Many people live in old plantation housing on back roads. Without public transportation, seeking medical help becomes a major problem. Many do not receive necessary care, so that when they do finally come to the doctor or the emergency room, they are much more ill.
5. With the threat of malpractice, many physicians practice "defensive medicine" and feel vulnerable when access to testing or specialists is not easily obtainable; hence, they tend to locate near large hospitals or in large cities where such services are available. (Again, this brings up the problem of transportation when patients require special care in Memphis or Jackson.)

GEORGE C. FURR
MCWILLIAMS BUILDING
CLARKSDALE, MS 38614

Access to medical care for the elderly in rural areas is influenced by lower allowable charges on the part of Medicare to rural physicians and hospitals. Reimbursement in rural areas creates a negative incentive to physicians and will ultimately reduce the number of practicing physicians in the Delta. Medicare lowers the reimbursement to Delta physicians per capita approximately 66% of urban areas.

Lower allowances also retard the medical profession's ability to do research to uncover causes for causitive agents that may be contributing to many chronic conditions in the elderly. If certain chronic conditions (such as cancer, heart disease, lung diseases, kidney disease, neuro and neuro-muscular diseases, etc.) could be reduced, much misery and medical expense could be alleviated and a more enjoyable life could be realized by the elderly and save the government billions of dollars as well.

HEALING THE DELTA

The area's widespread poverty is matched only by the self-sacrifice of its few caregivers.

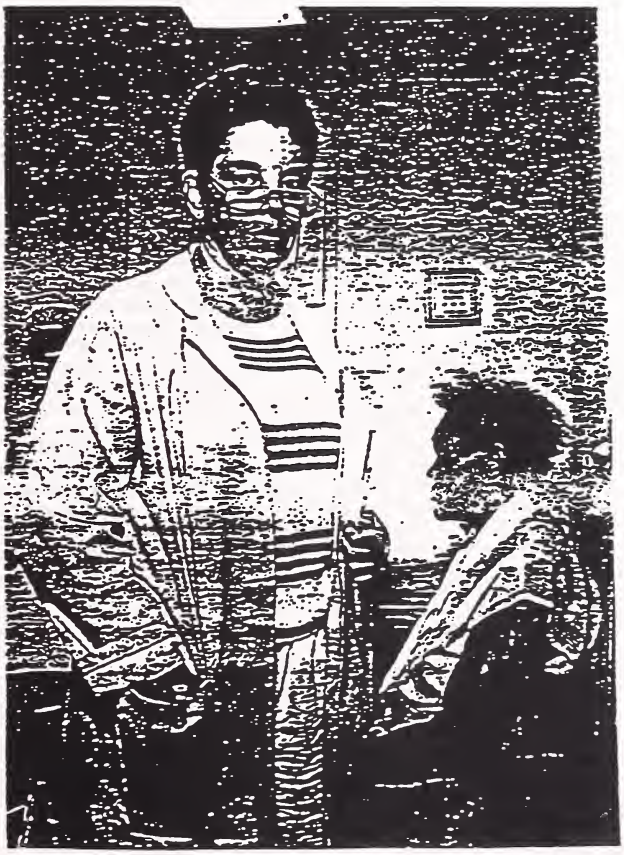
BY FRANK CLANCY

ON A SPRING AFTERNOON SEVEN YEARS AGO, A MAN ARRIVED AT DR. ANNE BROOKS' clinic near the Tutwiler, MS, post office with a sore back. He'd been chopping cotton in a nearby field—moving methodically up and down the rows, digging weeds with a hoe. Like most of Tallahatchie County's residents, he was black. ○ As a matter of principle, Brooks, a Catholic nun who trained as an osteopath, likes to suggest ways for patients to help themselves. In this case, her instinct was to recommend that the man spend the weekend in bed, putting hot towels on his back now and then. She thought for a moment, then asked if he had hot water. "No ma'am, I don't," he told her. "But I can heat the kettle." *How?* she asked. "I'll go outside, haul the water and chop some wood," he said, "then start a fire." Brooks told him to rest in bed, and perhaps ask a friend to rub his back.

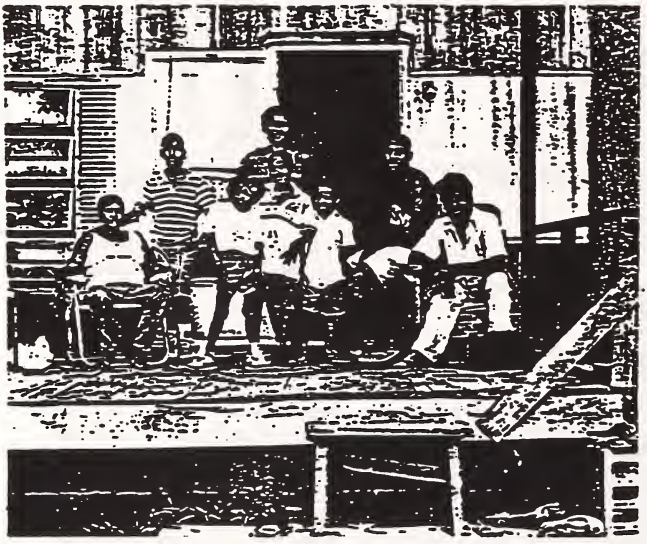
I had gone to Tutwiler, a town of 1,176 where W.C. Handy is said to have "discovered" the blues, in the hope of learning why black Americans in Mississippi and across the rural South are less healthy and dying younger than their white neighbors—what physicians call excess morbidity and excess mortality. For two weeks in May and June I crisscrossed the Delta in search of doctors, nurses and public health officials who might provide answers. I could as easily have gone to many of the other communities that make up the so-called stroke belt and have the highest infant mortality rates in the U.S. But in the Delta, where blacks constitute about 70% of the population and many are desperately poor, the problems are the most concentrated of any region in the country.

For more than 400 miles, from New Orleans to Memphis, U.S. Highway 61 roughly parallels the Mississippi River and passes within 20 miles of all but one of the towns I visited. It was my life line, the road to which I constantly returned, for most of these towns are too small and too poor even to have a motel of their own. North of Vicksburg, 61 descends to the vast flatlands of the Delta, a rich alluvial plain that supports beautiful harvests of wheat, rice and soybeans, along with the region's newest agricultural product, farm-raised catfish. And of course, there is the crop that made the Delta what it is today: cotton.

Time and again I discovered situations as complex and frustrating as Brooks's attempt to treat her patient's aching back. In the Delta, health and



DR. MARILYN AIELLO



relatively prosperous. As the seat of Quitman County, it sustains a decent-sized middle class. But soon I learn it is the white side of Marks that seems prosperous, for its housing is segregated, the railroad tracks as rigid a divider as the old Berlin Wall. As with legal segregation, separate does not mean equal: On the other side of the tracks are blocks of crooked wooden shacks, many built shotgun-style, with rooms stacked one behind the other. On one side of the tracks are street signs and fire hydrants, on the other, neither. Yet many black families have planted flowers in window boxes and in their front yards.

Aiello, a small, dark, gregarious woman who still retains a strong Chicago accent, traveled throughout the South before settling in Marks nine years ago. One of Marks's two doctors had died of cancer. Aiello and several other nuns moved into his office, and

"Poor black Americans, in terms of their health care, get written off. When the Public Health Service says, 'We don't want you to go to Tchula,' what they're saying is, 'We'll let those poor, rural black people die.'"

DR. RONALD MYERS
Private practice
TCHULA, MISSISSIPPI

medicine are linked inextricably to numbing poverty, lack of education and a social structure in which many blacks remain fundamentally powerless, unable to control their own lives. All of these forces are as entwined in local culture as the ivy that overwhelms abandoned buildings scattered across the landscape. If the pain of Brooks's patient cannot entirely be attributed to race, neither can race be absolved: White people do not chop cotton, and most white people do not live in houses without stoves and running water.

I learned, most of all, from the stories I heard. One nurse told me about a man who stood at the edge of a field waving a white flag to let a crop duster know where to spray, wearing only a T-shirt and jeans to protect him from raining poison. A physician described a patient hospitalized with massive gastrointestinal, urinary tract, liver and skin ailments after a spring wind soaked him with herbicide he was pouring into a container.

In Mound Bayou I heard about a man who lost his manufacturing job because he missed work to get X-rays, and the doctor told me of women whose employers "don't want them to go to a doctor even if they're half-dead."

I heard of one mother who fed her infant just twice a day, when the rice and of people forced to choose between food and heart medicine, because they didn't have money for both.

When black people in the Delta seek medical care, it's not in an integrated health care system but a haphazard patchwork assembly—one held together by too few physicians and fewer specialists. Their efforts are undermined by employers who fail to provide insurance, and Medicaid and Medicare systems that inadequately reimburse doctors and leave many patients uninsured.

"I'm not sure that the medical problems we face here in the Delta are a whole lot different from the medical problems anyplace in our country," says Brooks. "I think people are sicker longer before they get help, because of lack of money and transportation. When we finally get them in the hospital they're much worse off."

[redacted]

ON A HOT, DRY MORNING I DRIVE TO Marks, 20 miles north of Tutwiler, where I have arranged to interview another Catholic nun, Dr. Marilyn Aiello. With giant oak trees shading well-kept wooden houses, the town at first seems

named it the DePorres Health Center, after a 17th-century Peruvian saint who worked among and healed the poor. Like Brooks in Tutwiler, the nuns integrated the clinic's waiting room.

Poverty is the most overwhelming cause of poor health among black people in the Mississippi Delta: They are ill because they don't have the resources to remain well. "Your wealthier people, with cars, they can travel to Clarksdale, to Memphis, to Oxford," says the 53-year-old Aiello. "But your poor become very sick and die. I can't tell you how many people come into the clinic who have never seen a doctor, and are seriously sick—not so much any more, because I've been here almost 10 years. But in the beginning it was very commonplace. They just wouldn't go, because it was so hard for them to go."

Although she was for a time the only physician in the county, Aiello chose

Marks because she found another void as deep and significant as the absence of a doctor. "The poor need people who have a sympathetic ear, who will listen to them and help identify and further their interests—an advocate," she says. "Some of the places we went to, as much as there was a medical need, there were advocates. But when we came here, there were few advocates. We felt that we could offer something beyond health care."

That something might be as simple as seeing that specialists treat her patients with respect. It can mean teaching a woman to read, or having a fellow nun, Sister Juliana Beers, help a man apply for social security. With some—particularly the middle-aged men who live in sheds behind other people's homes—Beers can do little except help and there aren't many of those. Amtrak comes through Batesville (about 20 miles east of Marks). It's a steady stream up north."

Aiello would like nothing better than to help heal Marks's social divisions along with its disease. A number of the town's whites donate money to support Beers's work, and among Aiello's patients, white and black, there is friendliness and respect. "We don't want to divide people," Aiello says. "We're going to go home eventually. The question is, Will we leave things better or worse?"

COOPER-PANG EYE CLINIC, P.A.
361 MEDICAL DRIVE
CLARKSDALE, MISSISSIPPI 38614-8798

TELEPHONE (601) 627-2256

April 16, 1991

Senator Thad Cochran
United States Senate
Russell Senate Building
Room 236
Washington, D. C. 20515

Dear Senator Cochran:

I would like to call your attention to a provision called "Outpatient Services Limitation" enforced by Medicare in which as of 1991, laser procedures coded 67229, 65855, 66762, 66761 are considered in office procedures.

In my discussion with Medicare authorities, I was informed that this means that if a laser procedure is done in a hospital, I would be penalized 40% on my present reimbursement. Further questioning revealed that if I were to do this procedure in a free standing ambulatory care center, I would get my regular fee plus the ambulatory center would get a facility fee. It is also interesting to note that this facility fee is exactly the same as what the hospital presently receives. After further discussions, it appears I have only three options.

(1) I could continue to do my lasers at the hospital but be penalized 40% on my reimbursement everytime I do this.

(2) I could do my laser surgery at a free standing ambulatory care center, the only problem with this, there are no free standing ambulatory care centers in Clarksdale Mississippi.

[illegible] I could buy my own laser, I would be reimbursed at my present rate. However, I [illegible] facility fee. I pay my lasers cost from $41,000 to $70,000 and I lease lasers for approximately $25,000. This is a very expensive option.

Presently, I am taking a 40% loss with every laser procedure listed above. I do not have the option of number two above or number three which is too expensive. In checking with some of my cohorts, it appears that the doctors who are performing laser procedures in the larger cities have the use of free standing ambulatory care centers and do not see this problem. However, several of my cohorts who are practicing in rural areas of the country are taking a 40% loss. I fully understand that the Medicare system is in budget crisis and cuts must be made. It is noted that the laser procedures listed above have already been cut 8% this year and will be cut 8% again for total consecutive of three years for a total of 24% reduction. I can tolerate this in which all physicians are treated equally, however, the 40% cut as described above appears to be singling out physicians in rural areas and I feel that this is very unjust. I don't understand why the rural hospitals cannot be reimbursed like the free standing ambulatory care centers.

Your attention to the above problem will be greatly appreciated.

Yours sincerely,

Victor Pang MD

Victor G. Pang, M. D.

FACTS:

Medicaid allows 5 prescriptions per month. Medicare allows none.

PROBLEMS:

Medicaid requires the use of generic drugs whenever possible. This means that quality control is questionable. (Recent news stories highlighted the fact that some generic companies submitted brand name drugs to the FDA for approval as their product.) Doctors find that when generic drugs are used for heart arrhythmias or diabetes, it is not uncommon for a patient to suddenly become ill from lack of proper treatment. In many cases this requires hospitalization. And not infrequently, a diabetic has to go on daily insulin injections.

Elderly patients tend to have multiple health problems. Those who do not have Medicaid (and it is not uncommon for a cost of living increase in Social Security to bump someone's income a few dollars above the Medicaid level so they lose it) have to pay for medicines out of their meager incomes. Most commonly, this means they do not get the prescription filled; an alternative is to cut back on their food purchases in order to buy their medication.

Examples:

MB - 71 year old white female on Medicare.
Diagnoses: angina, high blood pressure, hypertensive heart disease, degenerative disc disease, vertigo, arteriosclerosis.
Medication (monthly) $144.25

WHM - 92 year old black female on Medicare.
Diagnoses: end stage heart disease with frequent episodes of heart failure and water on the lung; chronic obstructive lung disease, degenerative joint disease, osteoporosis, diverticulosis, high blood pressure, early kidney failure, anemia, weight loss.
Medications: $401.98/month.

IMT - 48 year old black female on Medicaid.
Diagnoses: asthma, diabetes, high blood pressure, hypertensive heart disease, recent blood clots in her leg.
Medication is $40.25 over what Medicaid allows per month.

NORTHWEST MISSISSIPPI REGIONAL MEDICAL CENTER, CLARKSDALE,MISSISSIPPI

Subcommittee on Aging
Wednesday, May 1, 1991

Recruitment Problems/
Aging of Physician Staff

NORTHWEST MISSISSIPPI REGIONAL MEDICAL CENTER
MEDICAL STAFF SPECIALTIES

DOCTOR	SPECIALITY	AGE 1991	AGE 1995
Dr. Marilyn Aiello	General/Family Practice	54	58
Dr. Rodney Baine	Emergency Medicine	46	50
Dr. Michael Ballentine	OB/GYN	38	42
Dr. Mike Barr	Orthopedics	37	41
Dr. Joseph Battaile	Psychiatry	56	60
Dr. Dave Berryhill	Internal Medicine	44	48
Dr. W. B. Bobo	Internal Medicine	71	75
Dr. William Booker	General/Family Practice	36	40
Dr. Anne Brooks	General/Family Practice	52	56
Dr. Pat Burke	Internal Medicine	50	54
Dr. Van Burnham	General/Family Practice	71	75
Dr. Joe Campbell	General/Family Practice	56	60
Dr. Charles Cesare	OB/GYN	36	40
Dr. Bill Clark	Radiology	50	54
Dr. Tom Cooper	Ophthalmology	47	51
Dr. Johnnie Cummings	Internal Medicine	34	38
Dr. Donald Ellis	GYN - Consulting	70	74
Dr. Marshall Ellis	Emergency Medicine	65	69
Dr. George Furr	General/Family Practice	76	80
Dr. Jonathan Harris	Internal Medicine	36	40
Dr. P. W. Hill	General Surgery	46	50
Dr. Scott Houston	Urologist	38	42
Dr. Shelby Howell	Emergency Medicine	35	39
Dr. W. B. Johnson	General Surgery	62	66
Dr. Tim Lamb	Internal Medicine	40	44
Dr. Julius Levy	General/Family Medicine	87	91
Dr. Carole Mangrem	Pediatrics	42	46
Dr. Bouldin Marley	OB/GYN	41	45
Dr. Frank Marascalco	GYN	68	72
Dr. Henry McCrory	OB/GYN	50	54
Dr. Robert McGee	Internal Medicine	66	70
Dr. Charles Nause	General/Family Practice	37	41
Dr. Victor Pang	Ophthalmology	32	36
Dr. Bill Pollard	Radiology	49	53
Dr. Thad Rodda	Pathology	54	58
Dr. Jack Sartin	General Surgery	65	69
Dr. Andrea Smith	Internal Medicine	37	41
Dr. Alan Snider	Anesthesiology	45	49
Dr. Walter Taylor	Cardiology	61	65
Dr. Glenn Wegener	GYN	62	66
Dr. Peggy Wells	Pediatrics	49	53
Dr. Otha Williams	General Surgery	49	53
Dr. Travis Yates	Internal Medicine	38	42

NORTHWEST MISSISSIPPI REGIONAL MEDICAL CENTER, CLARKSDALE,MISSISSIPP

Subcommittee on Aging
Wednesday, May 1, 1991

Social Factors

1. Our cultural ordering of priorities, we are a youth oriented society which results in health care for the elderly being low priority. Two few geriatric specialists!

2. Social isolation of the elderly - they become less involved in the larger community. Family support is often lacking due to the fact that so many adult children move north or to other areas of the country. The elderly are often unwilling or unable to get to medical care on their own without help. They are fearful of ending up in a nursing home or hospital. The fear of loss of independence is a definite barrier to health care for the elderly. We are too quick to recommend institutionalization.

3. Lack of transportation to medical care for elderly is certainly a barrier. Public transportation, when it is available, is often not geared for problems experienced by the elderly such as problems of incontinence, hearing and vision loss, etc.

4. Lack of financial resources to purchase medication. If elderly patients cannot afford to purchase drugs it does no good to "see the doctor".

5. Patients who need nursing home care are sometimes denied admission if they have too much monthly income to be eligible for Medicaid but not-enough money to pay to get in the nursing home as private pay. The Medicaid Commission will deny the application if the patient returns home from the hospital to await admission to the nursing home.

TESTIMONY OF:

Helen Wetherbee
Director, Mississippi Division
of Medicaid

In Mississippi, the elderly constitute a relatively high proportion (11%) of the population, and poor elderly even higher. Over 34% of the 280,000 Mississippians over 65 have incomes at or below the national poverty level, while in other states this figure is 5 or 6%.

Generally speaking, elderly persons with incomes at or below the poverty level are eligible for Medicaid if they are SSI recipients or if their resources do not exceed allowable SSI limits. For individuals living outside institutions, the threshold is an income of $552, and for couples it is $740. In addition, Medicaid will pay the Medicare copayments and deductibles for persons whose resources do not exceed 200% of the allowable SSI limits. Of the approximately 280,000 elderly Mississippians, 95,000 have incomes at or below the national poverty level, and 80% are receiving some sort of medical assistance through the Medicaid program.

Mississippi has initiated phased-in coverage of the elderly up to 100% of poverty before it became mandatory under OBRA '90. In addition, the state has expanded the eligibility staff to 100 workers and the number of regional offices to 24 sites in an effort to facilitate enrollment of the elderly and disabled. Division staff will work with applicants in their homes, in hospitals or nursing homes as necessary.

A primary barrier to care for the elderly is the low level of physician participation in the Medicaid program, as physicians' orders are a prerequisite to service. The Division of Medicaid, working with the State Medical Association and the University of Southern Mississippi, undertook a statewide survey in 1989 and 1990 to assess physicians' attitudes toward the program. While inadequate reimbursement ranked first as the cause for non-participation, other problems including patient abuse of the health care system and a perception that Medicaid patients are more difficult and more likely to sue were important factors affecting physician participation. In Mississippi, legislative action is required for any changes in the program, including reimbursement; and in July, a small increase in physician reimbursement will be implemented.

Another barrier to provision of care to the elderly is the serious lack of transportation. We are a rural state, and while transportation services must be provided to Medicaid recipients, these remain inadequate in many counties, and we continue to work with the state transportation agency as well as other human service agencies to develop new models in an attempt to address this problem.

An additional barrier is the fact that attempts to resolve problems of access to care are frustrated by the regulatory environment at both the federal and state levels. At the state level, the problem is compounded by the fact that the Division of Medicaid has no control over admissions to nursing facilities, home health services, or even its own home- and community-based services program. As a result, we have no way to ensure that the severely impaired, whether physically or mentally, are not rejected in preference for a recipient requiring less-intensive care. At the federal level, Mississippi has hardly been able to fund the mandated expansions of the last several years. These include not only the nursing home reform provisions of 1987, and the expansion of eligibility of the elderly up to 100% of poverty, but much greater expansion of coverage and services to pregnant women and children. In spite of the federal-state match of 4 to 1, there are not sufficient state funds to maintain Medicaid services to the high proportion of our citizen living at or below the poverty threshold. The forced expansions have lead to increases in program costs of 24% in fiscal years 1990 and 1991, and 49% for fiscal year 1992. The budget for FY 1992 is 1.1 billion dollars, while in 1990 it was $591 million. This figures represents the bare minimum necessary to maintain our current program and comply with OBRA '90. In the absence of sufficient state funds, provider assessments and donated funds will be used for state match, and the program is jeopardized by the prospect that these mechanisms will be restricted by subsequent federal legislation. As an alternative to this struggle to fund a "forced" program, Mississippi is among the states supporting the proposal that federal legislation afford the states some period of time, such as two years, in which to meet the latest mandates. Less pressure on the state budget would also permit us to assume some initiative in developing programs and services particularly suited to our state.

In searching for a solution, one must note that nursing home residents constitute 4% of our total Medicaid population, while the cost of long term care consumes 30% of the medical services budget. In January of this year, more than 75,000 Medicaid recipients were over 65 years of age. With respect to all Medicaid services, the cost per elderly client was $3,214, while, as a point of comparison, the cost per recipient under 21 years was $852. Of the elderly Medicaid recipients, 20,000 resided in nursing homes, for an average cost of $7,577. While there was a 23% increase over the past year in the number of elderly recipients, there was a 43% increase in the number of elderly recipients residing in nursing homes. Clearly, less costly alternatives to nursing home care are needed.

Mississippi has initiated a small home- and community-based program. For 500 recipients, a special battery of services offers an alternative to institutionalization. These include case management, expanded home health, homemakers, respite care and adult day care services. The annual cost is $2,000 per recipient. This program should be expanded, but it is an optional service, and the legislature has refused to fund any optional expansions because of the cost of implementing those that have been federally mandated.

Another way in which Mississippi Medicaid hopes to address the problems of access is through the development of a managed care program for the frail elderly. The Mississippi Legislature has authorized two pilot programs which we are presently in the process of developing. In establishing a medical home for the elderly client, we hope to facilitate access to needed services and prevent duplication or overlapping of services, and most especially, drugs.

Finally, some fundamental questions underlie the role of the Medicaid program in meeting the health care needs of the elderly. Remembering that at its inception, Medicaid provided limited medical assistance to limited categories of low income people, the elderly have been relatively well served by the program. In recent years, however, federal priority has been placed upon pregnant women and children, now served in some instances up to 200% of poverty and provided all medically necessary services without restrictions that have been used in the past to control costs. Currently, 15% of Medicaid recipients in this state are over 65, while the cost of their services is nearly 40% of the program budget. Some health analysts

now question whether Medicaid should serve the elderly at all, or whether all their health costs should be shifted to Medicare. Lack of Medicare coverage of certain preventive services arguably drives up the costs to Medicaid. There are questions whether nursing homes may properly be considered a medical service, and whether their exorbitant cost should be paid by the Medicaid program. It is also unclear to what extent Medicaid should fund non-medical services such as meals, homemaking, and adult day care.

In conclusion, the Medicaid program in Mississippi is playing a major role in providing traditional medical services to the elderly with incomes below the poverty threshold. It appears that the reimbursement for these recipients will total $250 million this fiscal year. This money is being spent on long-term care and inpatient hospitalization, and the costs are overwhelming. However funded, there is a definite need for increased home and community services, as these will avert institutionalization, enabling our clients to remain at home in their communities while helping to reduce the increasing costs to the state.

THE MISSISSIPPI LONG TERM CARE SYSTEM

AN INITIAL EVALUATION

INTRODUCTION

An on-sight evaluation of the Mississippi long term care system was made from Monday, December 18, 1989 to Friday December 22, 1989. All five days of the on-sight evaluation were spent in the Jackson area, with the exception of a field visit to Vicksburg on Thursday December 21, 1989. Interviews were conducted with all Medicaid staff having long term care responsibilities in the Jackson central office. In addition, interviews were also held with Medicaid field staff in Jackson and Vicksburg. Interviews were also held with representatives of the Independent Nursing Home Association, the Mississippi Nursing Home Association, the Mississippi Health Department, the Vocational Rehabilition Department, The Mississippi Council on Aging, the Mississippi chapter of the American Association of Retired Persons, and the Central Mississippi Planning and Development District. Two field visits to Jackson area Nursing homes were made on Friday December 22, 1989.

I would like to thank all of those who spent time with me, educating me about Mississippi and the Mississippi long term care programs. I would especially like to thank Max Cole of the Mississippi Division of Medicaid for so graciously spending his valuable time with me, educating me about Mississippi and providing transportation, it was much appreciated. I would also like to thank the operators of the two Nursing Homes in the Jackson area for alloving me to visit their facilities.

The following evaluation is made with little knowledge of the legislative and executive priorities in Mississippi. Therefore, some of the recommendations made may not be politically viable. The recommendation are based on my 10 years experience operating Oregon's long term care system, upon my knowledge of long term care systems in several other states, and upon knowledge gained from serving on the Boards of Directors of four National Organizations concerned with long term care. While I make comparisons to Oregon, Florida, and Texas in this report, I do not recommend that Mississippi adopt any of these States' systems of long term care. Such a recommendation would not recognize the unique problems in Mississippi nor the valid different approaches in each state to delivering Social and Medical services.

This report will make recommendations regarding certain aspects of the Oregon long term care program that are shared by several other states. This is done because these programs appear to be appropriate for Mississippi, and should not be interpreted as an attempt to replicate Oregon programs in Mississippi.

GENERAL OVERVIEW

Mississippi is probably unique among states in terms of poverty and available State General Funds. Mississippi has the highest Medicaid match rate in the Nation (about 80% Federal funds). The level of poverty in Mississippi has a direct bearing upon the Medicaid program: First, the percentage of persons eligible for Medicaid is much higher in Mississippi, and second, the general health of the population, especially the elderly can be assumed to be poorer than that found in the rest of the country. Table 1, compares Mississippi and Oregon populations and Medicaid eligibles who have received a Medicaid service. While both states are of similar population, and both have similar Medicaid eligibility criteria; Table 1 shows Mississippi has 2.5 times more elderly Medicaid eligibiles than Oregon.

TABLE 1
MISSISSIPPI AND OREGON MEDICAID
COMPARISON OF POPULATION AND MEDICAID ELIGIBLES
WHO HAVE RECEIVED A MEDICAID SERVICE
1988-1989 FISCAL YEAR

SERVICE	OREGON	MISSISSIPPI	DIFFERENCE
POPULATION 65 PLUS	376,000	321,000	55,000
65 PLUS MEDICAID ELIGIBLES	22,830	57,395	-34,565
PERCENT ELIGIBLES TO POPULATION	6.07%	17.68%	-11.61%

POPULATION BASED ON UNITED STATES BUREAU OF CENSUS SERIES P-25.

MISSISSIPPI MEDICAID ELIGIBLES BASED ON MEDICAID DRAFT REPORT DOM-89-R1. OREGON DATA BASED ON SIMILAR REPORTS.

High poverty levels in Mississippi means less State General Fund revenues than other states enjoy. This in turn probably points to more difficulty in obtaining funding for long term care, than would be the case in other states. The high match rate in Mississippi, at first glance, seems an advantage for

program expansion and improvement; however, Medicaid match rates are based on a states' ability to provide necessary funding, which as already stated is much more difficult in Mississippi.

The high match rate in Mississippi provides a disincentive for being innovative and creative in Medicaid programs. Innovation in Medicaid programs, especially in the last 10 years, raises the risk of receiving a disallowance on Medicaid funds. Such a disallowance in Mississippi means that the state must repay the federal government their share of expended funds: about 4 times the amount spent by Mississippi originally. Medicaid disallowances, create a hardship in all states; in Mississippi, however, they could well be a catastrophe.

The recommendations made in this report have taken into account the ability of Mississippi to generate additional State General Funds for Medicaid and long term care, and the difficulty of absorbing a Medicaid disallowance. All recommendations in this report are based on Medicaid programs operating in several other states for several years. In addition, the recommendations are designed to reduce futnre liability in long term care.

The strength of the Mississippi long term care system is based on the people working in that system. As a whole they are among the most dedicated and enthusiastic I have encountered in the 20 or so state long term care program I have studied. Mississippi has one of the lovest Medicaid Administration ratios in the country (3.1 percent). Such a lov administrative ratio means that Mississippi Medicaid has relatively fever people to administer the Medicaid program than other states, vhich in turn probably means higher vork loads. Despite this situation, the morale of the staff of the Division of Medicaid appeared to be high.

While the Mississippi long term care system has much room for improvement, it is not the vorst system I have encountered. There are several aspects of the long term care system that could be used as models for other states. For example, the Nursing Home reimbursement system is probably the strongest I have encountered, and the proposed case-mix system is the best I have seen. The veakest aspect of the Mississippi long term care system is its heavy dependence on Nursing homes to provide the majority of long term care, and its lack of a viable non-medical housing option for the functionally impaired elderly.

CURRENT SITUATION

Mississippi has a long term care system designed to contain costs, and does so quite well. Cost Containment in Mississippi, however, is accomplished by limiting resources, not by controlling the system. Indeed, the supply of Nursing Home beds is limited by a moratorium on nev Certificates of Need. Home Health is limited to 50 visits. The Home and Community Based Waiver is limited to a total of 400 people. Utilization of available services is on a first come, first served bases, not on any priority method based on level of impairment.

Mississippi Medicaid has little control over the long term care system. The Department of Health determines level of care and appropriate placements to Nursing Homes and Home Health. Physicians determine vho is essentially going to be able to access these long term care programs. The Mississippi Council on Aging determines vho will access the Medicaid Home and Community Based Waiver program. Medicaid control is primarily limited to verifying Medicaid eligibility. Mississippi Medicaid to a very large degree is responsible for a long term care budget mostly controlled by other state agencies.

There was almost universal agreement among people interviewed (including Nursing Home operators), that up to 25 percent of current Nursing Home residents could benefit from alternative placements, if these were available. During my visit to two Nursing Homes in the Jackson area, I noted several people who would not be placed in Nursing Homes in other states. Indeed, I noted a few who would not even be eligible (because of impairment levels) for any long term care services in my own state of Oregon.

Because all long term care services are operating essentially at capacity, and because placements are not based on impairment levels, but rather on a first come, first served bases; one can speculate on how many Mississippi citizens in need of long term care services are being denied access. Fairly long waiting lists for available services appear to be evident in most areas. While "waiting lists" are usually not very valid in most states, one can wonder about their validity in Mississippi.

Recommendation

Mississippi Medicaid needs to exercise more control over the long term care system. It must be assured that the most impaired have first priority on available services. This recommendation is a prerequisite to all other recommendations made in this report. Without control over utilization of long term care services, Mississippi will never know how many long term care services are needed. In addition, Mississippi will not know what the distribution of services ought to be: How many Nursing Home beds are really enough, how much Home Health and Home care is appropriate, and how many non-medical housing slots should be developed. Probably the easiest and quickest way to implement this recommendation is to take two actions:

- An assessment instrument that measures impairment levels needs to be instituted and required for all applicants to Nursing Homes. This should be broadened to all services as quickly as feasible. The "Minimum Data Set for Nursing Facility Resident Assessment" form proposed for the case-mix reimbursement system could also be used as an instrument to determine initial impairment eligibility, and priority for placement in Nursing Homes and other services.

- Mississippi needs to adopt a Pre-Admission Screening program. This program, which is currently being used by most states, usually consists of a Nurse and Social Worker, who pre-screen applicants to Nursing Homes for appropriateness of placement. Perhaps the best Pre-Admission Screening program is in the state of Virginia. This was the first one developed in the country, and pre-screens all applicants to Nursing Homes who are Medicaid eligible or will become Medicaid eligible within 180 days. The states of Minnesota and Indiana have pre-screening programs that not only screen Medicaid clients but all other clients as well.

On the surface, the above recommendations would appear to cost the state of Mississippi more money. This is certainly not the intention of this recommendation. All costs associated with Pre-Admission Screening and the assessment instruments should be more than recovered from savings in appropriate utilization of services. In fact, all states that I am aware of, who have instituted Pre-Admission Screening, have done so as a cost-containment measure.

Home Health

Table 2 shows the age distribution for all Medicaid long term care services.

TABLE 2
MISSISSIPPI MEDICAID
PERCENT OF ELIGIBILES RECEIVING SERVICES
COMPARISON OF AGED TO NON-AGED CLIENTS
1988-1989 FISCAL YEAR

SERVICE	PERCENT AGED (65+)	PERCENT NON-AGED(64-)	PERCENT TOTAL
NURSING HOMES	85.36%	14.64%	100.00%
HOME HEALTH	24.07%	75.93%	100.00%
MEDICAID WAIVER	59.44%	40.56%	100.00%
TOTAL	76.47%	23.53%	100.00%
TOTAL WITHOUT HOME HEALTH	84.68%	15.32%	100.00%

DATA BASED ON DIVISION OF MEDICAID DRAFT REPORT DOM-89-R1
NURSING HOMES EXCLUDE ICF\MR

Table 2, shows that all Medicaid long term care programs predominately serve the elderly, except Home Health. Mississippi has made Home Health the primary non-institutional service for persons requiring long term care, however, it appears this service is being utilized mostly by the non-elderly when Medicaid pays the bill. If you are old, poor and need long term care services in Mississippi, you are most likely headed for a Nursing Home.

Mississippi Medicaid utilizes more Home Health than most other states. We [illegible] for 90 percent of all Medicaid Home Health in the United States, and it seems quite likely that Mississippi may be the second highest user. Most states have moved away from Home Health as a long term care program, because of its high unit cost and because it is essentially an acute medical service; and therefore not designed to provide cost effective care to the chronically impaired. Oregon for example, only served 141 clients in its Medicaid Home Health program in 1988, as compared to the 3,360 served in Mississippi.

Most states, with Mississippi being one of the possible exceptions, have also seen another phenomena concerning Home Health in recent years. After the advent of the Medicare DRG (Diagnostic Related Groups) Hospital reimbursement system in the early 1980's, new Home Health agencies were established all over the country. It was anticipated that shorter Hospital stays would mean more business for Home Health agencies. To some degree this was true, however, in most areas of the country too many Home Health agencies were created, and subsequent competition and more stringent regulation by the federal Health Care Financing Administration, have caused many Home Health agencies to close.

County Home Health agencies were at one time operated in most states in the country. In recent years many states have seen these operations go out of business. Indeed, it is very hard for county operations to remain in business, since they are

usually obligated to pay staff more than private operations. Without some kind of government subsidy County operated Home Health agencies are hard pressed. Mississippi appears to be subsidizing its County operated Home Health agencies through the Medicaid program.

Mississippi Medicaid seems to have no control over Home Health whatsoever. There is a 50 visit limit, but since the average client receives 30 visits, this is in reality not a control. The Health Department issues licenses and certifications to Home Health Agencies. It also controls the Certificate of Need process required for Home Health. The Health Department, in addition, also determines who needs Home Health services, and if they are poor and under 65 (or have exhausted their Medicare benefits if over 65), Medicaid receives the bill.

Recommendation

It is difficult to make any recommendations concerning Home Health in Mississippi, because of the lack of information about the people using Medicaid Home Health, and the types of Home Health services they receive. Do most of the persons receiving Home Health in Mississippi have acute complex medical problems, or are large numbers of them chronically impaired? For all Home Health services regardless of funding source, Mississippi Home Health agencies report that about half of all clients and half of all visits are for Home Health Aide. Does this percentage hold for Medicaid clients, and if so is this excessive? I found little data in Mississippi that would answer these questions, nor did I interview anyone who knew the answers. Until these questions are answered any recommendation would have to be based upon guess-work and may not be valid.

I would recommend, however, that the Division of Medicaid and the Department of Health begin negotiations on the Home Health program. These negotiations should center on attempting to answer the above questions about Home Health, and upon the viability of substituting Private Duty Nurse and Personal Care for some of the Home Health services. Both Private Duty Nurse and Personal Care are optional benefits under Medicaid, and both are utilized by many states. It is also possible to limit the providers of these services to Home Health agencies (as long as freedom of choice is not violated), and the amount of services available (as long as that amount is the same statewide).

Home and Community Based Waiver

Mississippi operates a small Federal 2176 Medicaid Home and Community Based Waiver in four locations, with each location being limited to 100 clients. The Mississippi Council on Aging through local Area Agencies on Aging operate the Waiver program in cooperation with the Division of Medicaid. All recipients must be eligible for Medicaid outside of an institution, and be judged in need of services, without which they would be likely to enter a Nursing Home.

Services offered through the Waiver include:

- Case Management
- Adult Day Care
- Home Health beyond the 50 visit limit
- Respite Care
- Homemaker

These services appear to be standard services offered in many of the 47 states that operate Waiver programs in the country. The two exceptions to this observation are Home Health beyond 50 visits and Case Management. Most states do not offer Home Health as a 2176 Waiver program, since it is not usually considered a viable alternative for the chronically impaired. Case Management is more medically oriented in Mississippi with a Nurse and Social Worker performing this function. Most states would have the Social Worker alone doing case management.

The Mississippi assessment form MCC 260 is used to determine the need for Waiver services and certifies that the client is at the Skilled or Intermediate level of care. This form does not measure the impairment level of the client, and consequently does not allow evaluators to determine if the impairment profiles of Waiver clients match the impairment profiles of Nursing Home clients.

The application for the Mississippi 2176 Waiver stated in part: "The State proposed (sic) to conduct on a pilot basis a limited program, as authorized by the 1985 Mississippi Legislature, to determine the cost effectiveness of initiating a Home and Community Based Services program on a Statewide basis as opposed to building additional nursing homes". Mississippi will be able to certify that all clients in the 2176 Waiver program meet the criteria for Nursing Home placement. It will not be able to ascertain whether or not 2176 clients are less impaired than Nursing Home clients, nor whether 2176 clients would have actually been placed in a Nursing Home absent the Waiver program.

Recommendation

Mississippi should implement for 2176 Waiver clients, as soon as possible, the Pre-Admission Screening program recommended earlier in this report. In addition whenever possible 2176 Waiver clients should have either applied directly for a Nursing Home placement or have been relocated from a Nursing Home to the 2176 Waiver program. Reassessment of 2176 Waiver clients should also be done with the "Minimum Data Set" assessment instrument recommended for the Pre-Admission Screening program.

Mississippi is proposing that the 2176 Waiver be expanded to ten sites. Whether or not this will be cost effective, depends on whether 2176 Waiver services are utilized as a substitution for Nursing Homes or in addition to Nursing Homes. I submit that this question cannot be answered with any degree of accuracy with current data, and current procedures for determining 2176 Waiver clients.

Nursing Homes

Table 3 shows the comparisons between Mississippi and some selected other states on Nursing Home utilization.

TABLE 3
A comparison of nursing home bed to population ratios
Per 1000 age 65 plus, age 75 plus, and age 85 plus
In Mississippi, Florida, Oregon, and Nationally*

AGE COHORT	MISSISSIPPI	FLORIDA	OREGON	NATION
65 PLUS	46.6	27.0	37.4	52.4
75 PLUS	110.7	66.1	83.4	117.8
85 PLUS	482.2	332.1	322.4	437.3

*ESTIMATE BASED ON AVAILABLE 1989 DATA. FOR MISSISSIPPI INCLUDES 14,949 REPORTED NURSING HOME BEDS ON DECEMBER 31, 1988 (EXCLUDING 1,622 ICF/MR BEDS). DATA ALSO BASED ON UNITED STATES BUREAU OF CENSUS SERIES P-25 POPULATION ESTIMATES FOR MISSISSIPPI IN 1989 OF 321,000 AGE 65 PLUS, 135,000 AGE 75 PLUS, AND 31,000 AGE 85 PLUS.

Table 3 shows that Mississippi is below the National average for the age cohort of 65 plus and 75 plus, but above the National average for the age cohort of 85 plus. When compared to Oregon the state of Florida also follows this trend, with Florida being substantially below Oregon at the age 65 plus and 75 plus cohort level, and above Oregon at the age 85 cohort. The reason for this phenomena in Florida is a substantial in-migration of elderly under about age 70, and substantial out-migration of elderly over about age 80. This could also be a contributing factor in Mississippi. It could also be true that Mississippi has less age 85 plus folks, because the poverty level has meant more health problems and limited access to health and long term care programs.

Mississippi has chosen to invest [illegible] of its Medicaid funding for long term care in Nursing Homes. This has resulted in Nursing Home being the primary provider of long term care services. Having implemented a Nursing Home dependent long term care system, Mississippi then chose to control costs by placing a moratorium on new Nursing Home construction. This was done without an apparent concomitant effort to implement additional alternative services. On the surface, it would appear that Mississippi has made a decision not to serve increasing numbers of its population needing long term care services. However, interviews with the leadership of the Division of Medicaid would indicate this not to be the case. A strong commitment to the expansion of alternatives was ,indeed, noted.

Mississippi has invested heavily in long term care services which operate under the Medical model. These services (Nursing Homes and Home Health) are the most expensive long term care services to provide, and assume that most long term care clients need medical care. Most other states have come to the opposite conclusion. The general percentage of long term care clients needing complex medical treatment around the country is small, usually around 10 to 15 percent. The general percentage of long term care clients needing routine medical care (mostly medication management) is higher, usually around 50 to 60 percent. Most states have found that routine medical care need not be provided in a Nursing Home or through Home Health, and have successfully provided these services in many alternative settings.

Recommendation

While this report appears to speak against the Nursing Home Moratorium on Certificate of Need, it is recommended that this moratorium remain in place. It is also recommended that Mississippi continue and even expand its efforts to provide alternative services to its increasing population in need of long term care services. Mississippi will conclude, as most other states have already concluded, that it is much less expensive to provide alternative services to a large portion of its long term care population. A balanced long term care system will assure that only those in need of higher levels of care (Nursing Homes and Home Health) utilize those services, and that others in need utilize the less costly alternatives.

This recommendation will also direct Mississippi towards the wishes of the elderly and disabled. Interviews conducted with representatives of the disabled community revealed their very strong desire not to receive services in Nursing Homes. Indeed, they stated their intention to actively lobby the Mississippi Legislature for more alternative services. A recently completed needs assessment of older adults conducted for the Mississippi Council on Aging by Butler and Associates of Jackson, Mississippi and Data Analysts and Research Consultants, Inc. Winter Park Florida; indicated that 79 percent of the elderly interviewed did not want their long term care needs provided in a Nursing Home if other alternatives were available.

Long term care is essentially a social and functional problem, not a medical problem. A quote by Dr. Rosalie Kane of the University of Minnesota helps illustrate this point: "Long term care consists of those personal care and supportive services needed to compensate for functional limitations....the long term care services themselves are often Unspecialized and Untechnical. The functional impairments of older people can be divided into those affecting the ability to do basic Personal Care, and those affecting the ability to Manage a Household."

As a part of these recommendations, it should be noted [illegible] myself visits I encountered a disturbing situation [illegible] quality of care in Nursing Homes. One of the two Nursing Homes visited, I would rank among the best, if not the best, of the scores of Nursing Homes I have visited over the years. Unfortunately, the other Nursing Home was among the worst I have seen. While all states have their share of good and bad Nursing Homes, Mississippi may be unaware of this situation. I was informed by the Department of Health that only 166 abuse complaints were received last year and that 50 percent were substantiated. Oregon which has about 3,000 fewer Nursing Home beds and a lower occupancy rate than Mississippi revieved 1,868 Nursing Home complaints last year with a substantiation rate of 34 percent.

Homecare

Home care is provided by the Mississippi Council on Aging through local Area Agencies on Aging. An estimated 4,720 clients receive this service in Mississippi. Case managers are used to control the Homecare program (as well as other services), and determine who will receive services and at what level. Funding for Homecare is primarily through Titles III-B and III-D of the Older American Act and through the Social Service Block Grant. Neither of these funding sources can be use for Medicaid match.

Case Managers use a Pre-Screening Form to determine the need for Homecare services and a Client Assessment Schedule to determine appropriateness of services needed to maintain the client in their own home. The Pre-Screening Form is not very sophisticated when compared to other such forms in use in the country, and results in a "screening score" which determines the need for services. Clients must receive a score of at least 22 to be eligible for Homecare. The Client Assessment Schedule is mostly a narrative form. This type of form, while popular with case managers, does not provide much comparative data for planning additional services.

Table 4 shows the three primary services offered by Mississippi as alternatives to Nursing Homes. The three services shown in Table 4: Homecare, Medicaid Waiver, and Home Health were chosen because they are either funded through Medicaid (which is the major source of long term care funds in the United States), or because they are seen as having the most effect on Nursing Home utilization. This is the case with Homecare. Other services offered by the Mississippi Council on Aging, such as Home Delivered Meals, Transportation, Chore services, Respite Care, and Adult Day Care are important long term care services, but have not been included in Table 4 because of their disputed effect on Nursing Home usage.

TABLE 4
MISSISSIPPI HOME CARE
1988-1989 FISCAL YEAR

SERVICE	CASES	UNIT COSTS	TOTAL COSTS	% OF TOTAL
MCOA HOMECARE	4,720	$ 34.56	$ 1,957,660	56.06%
MEDICAID WAIVER	339	$ 182.48	$ 742,340	4.03%
HOME HEALTH	3,360	$ 79.19	$ 3,193,053	39.91%

BASED ON DATA RECEIVED BY THE MISSISSIPPI COUNCIL ON AGING, AND MEDICAID POLICY PLANNING AND RESEARCH. UNIT COSTS ARE AVERAGE MONTHLY COSTS PER CLIENT.

As Table 4 indicates, Homecare may well be the best bargain Mississippi has available in long term care. Unfortunately, there is no way of knowing, without better comparative data, what success this program is having as an effective alternative to Nursing Homes.

Recommendation

It is recommended that the Division of Medicaid open negotiations with the Council on Aging. The prime target of these negotiations should be the utilization of the same assessment tool used by Medicaid (the Minimum Data Set) for Homecare (and other Council on Aging services). If it can be shown by use of a common assessment tool, that Homecare (and other services) are an effective alternative to Nursing Homes, then it should be easier to obtain additional state and local funds for future expansion of this program. These funds could then be used to leverage additional Medicaid funds through the Personal Care optional Medicaid program, currently utilized by 22 states.

Personal Care Homes

Mississippi has 86 Personal Care Homes with about 1,500 beds. These homes vary in size from 2 beds to over 100 beds. Mississippi spends no State General Funds on this service, and apparently has no plans to do so. According to the Department o Health the quality of care in these homes is either very good or very bad, with fev homes being mediocre. Mississippi has not considered a housing option as a primary long term care service.

Recommendations

Long term care is a fairly simple concept. Persons who require long term care most often do so because they can no longer perform one or more activities of daily living (such as dressing, grooming, eating, toileting, cooking, ambulating, bathing or medication management), or have a cognitive problem. A percentage of these people also have medical problems that require complex nursing intervention, but this percentage is usually small (between 10 and 15 percent). Historically in the United States ve have treated chronic long term impairments as a medical problem, and have relied upon nursing homes (a medical service) to provide the primary care.

More and more experts around the country are becoming convinced that most people could receive long term care service outside of a nursing home. The general consensus is that any viable long term care system must have three components, and that these components must be available in sufficient numbers to meet the needs of the long term care population. These components are:

- A Home Care program which provides a vide array of services that meet the needs of most of the people requiring long term care services,

- A Housing program which provides the same services that are available in the Home care program, and

- A Nursing Home program which provides services to those most impaired and those with complex medical problems.

Mississippi currently has two of the three components. Some might say that two out of three ain't bad, but if the State of Mississippi is to limit its future liabilities in long term care it must develop as quickly as possible the third component. Personal Care Homes as currently structured in Mississippi, are not designed to be an alternative to nursing homes. Mississippi must have a viable Housing alternative that provides the services available in the Home care program, or it must expect to expend additional funds to maintain it's level of effort in long term care.

People in need of long term care services enter nursing homes for three reasons: Either they require complex medical attention, are too impaired for most alternative services, or they can no longer stay at home and require a housing option. It should be noted that a Housing option with services are usually required not because a person has necessarily become more impaired, but most often because they require night-time care, 24 hour supervision, or more than intermittent services. If no viable housing option is available, then these people will most likely move to nursing homes.

Adult Foster Homes

The easiest and cheapest way for Mississippi to create a viable Housing option is probably through Adult Foster Homes. To be a reliable and viable option the program should have most of the following characteristics:

- The allovable size of Adult Foster Homes should be at least 5 and preferably 6.
- Adult Foster Homes should be alloved to have a mix of private and Medicaid clients (up to the 5 or 6 limit).
- Adult Foster Homes should be alloved to care for incontinent clients if they are equipped and trained to do so.
- Ambulatory restrictions should allov for placement of the partially ambulatory and at least one or two clients that are vheel-chair bound.
- Specialized Adult Foster Homes operated by licensed medical staff should be alloved. This type of home is becoming popular for specialized populations such as those with AIDS or those recovering from strokes.
- Outside services such as Home Health should be alloved on a short-term basis.

In addition, Medicaid funding for Adult Foster Homes is available by tvo methods: either through the 2176 Home and Community Based Vaiver program, or through the Personal Care Optional Medicaid program. It should be noted here that since the federal government has defined the SSI payment (about $350.00) to be the level of board and room needed, any amount paid to an Adult Foster Home above that level can be matched by Medicaid as a service payment. Several states around the country have instituted Adult Foster Homes and both methods of Medicaid funding are being used.

Adult Foster Homes can be a viable alternative to [illegible] for a large percentage of the population requiring long term care. Two additional changes, however, are recommended: First, staff should be assigned in each district to recruit, orient, train, and license Adult Foster Homes; and second, staff should be assigned to nursing homes to identify clients who could benefit from a less dependent placement. Once these clients are identified, and if they chose to do so, they should be relocated from nursing homes to Adult Foster Homes. A relocation training program should be initiated to assure that all relocations are safe and do not increase transfer trauma.

The above recommendations concerning Adult Foster Homes vould appear to be quite costly. Indeed, I am recommending later in this report that Mississippi move over the next five years toward spending between 3.6 and 6.0 million a year on Adult Foster Homes. As also will be seen later in this report about double that amount of funds will be saved in Medicaid if this recommendation is adopted. This report also recommends an average service payment of $200.00 above the SSI payment of about 350.00 to support Adult Foster Homes. This is a close approximation to vhat is judged to be about right in Mississippi. I recommend that Mississippi adopt a reimbursement system for Adult Foster Homes based on the case-mix system proposed for nursing homes, vith clients requiring more care receiving a higher rate and those requiring less care receiving a lover rate.

About 9 additional staff would be required to implement an Adult Foster Home program serving 1,500 clients, with about 5 more additional staff required for each additional 1,000 clients Current District field office staffing levels would appear to allow this additional staffing effort to be absorbed. However, changes in Mississippi Medicaid eligibility may change this conclusion.

Mississippi may set limits on Adult Foster Home services if it adopts this program. These limits are easier under the 2176 Waiver program, since the 2176 Waiver already has approved waivers to 1902(a)(10)(B), amount, duration and scope requirements, and 1902(A)(1) statevideness requirements. No payment for board and room is eligible under Medicaid for Adult Foster Homes. Personal Care services must be provided in the clients ovn home. Several states have interpreted this to mean that the Adult Foster home is, indeed, the persons ovn home. Such state plans have been approved in Texas, Nev York, and Michigan. Attached to this report for use by planners is a copy of the approved Oregon Personal Care state plan.

POSSIBLE 1994 SITUATION

Table 5 shovs a comparison between Mississippi, Texas, Florida, and Oregon current long term care programs. Oregon vas chosen because of available data from that state and because it has about the same population as Mississippi. Texas and Florida vere chosen because they too are southern states and the available data are good. Table 5 shovs that Mississippi has invested more heavily in Nursing Homes than any of the other 3 states. It also shovs hovever, that Home care is becoming more of a viable option (Mississippi Home care in this Table includes Council on Aging Homecare, 2176 vaiver services, and Home Health). Texas like Mississippi has not invested very heavily in non-medical housing options.

TABLE 5
A comparison of Mississippi, Texas, Florida, and Oregon
Long term care cases, unit costs (per month), and total costs
For fiscal year 1988-1989

SERVICE	MISSISSIPPI	TEXAS	FLORIDA	OREGON
ADULT FOSTER HOMES				
CASES	0	566	389	2,256
% ALL CASES	0.0%	0.51%	0.45%	11.14%
UNIT COSTS	$ 0.0	$ 297.74	$ 107.11	$ 324.52
TOTAL COSTS	$ 0	$1,900,000	$500,000	$8,785,306
RESIDENTIAL CARE HOMES (BOARD AND CARE)				
CASES	0	819	5,341	967
% ALL CASES	0.0%	0.74%	6.15%	4.77%
UNIT COSTS	$ 0.0	$ 457.87	$ 121.70	$ 243.53
TOTAL COSTS	$ 0	$4,500,000	$7,800,000	$2,825,935
HOME CARE				
CASES	8,419	53,803	48,375	9,551
% ALL CASES	42.20%	48.48%	53.68%	47.16%
UNIT COSTS	$ 58.33	$ 261.14	$ 97.85	$ 211.66
TOTAL COSTS	$5,893,053	$168,600,000	$56,800,000	$24,260,939
NURSING HOMES				
CASES	11,530	55,800	32,778	7,480
% ALL CASES	57.80%	50.27%	37.72%	36.93%
UNIT COSTS	$ 889.54	$ 782.24	$ 1,470.75	$ 1,072.84
TOTAL COSTS	$123,076,148	$523,790,246	$578,500,000	$96,293,274
TOTAL				
CASES	19,949	110,988	86,883	20,254
% ALL CASES	100.00%	100.00%	100.00%	100.00%
UNIT COSTS	$ 538.75	$ 524.67	$ 617.30	$ 543.80
TOTAL COSTS	$128,969,201	$698,790,246	$643,600,000	$132,170,454
APPROXIMATE STATE FUNDS	$ 25,400,310			$ 53,502,600
AGE 75+ POP.	135,000	747,222	962,310	159,133
TOTAL CASES AS % OF AGE 75+	14.78	14.85	9.03	12.73

THE AMOUNT OF UNIT COSTS FOR BOTH ADULT FOSTER HOMES AND RESIDENTIAL CARE DO NOT INCLUDE BOARD AND ROOM PAYMENT OF APPROXIMATELY $ 350.00 PER MONTH. OTHER FIGURES ARE ESTIMATES BASED UPON BEST AVAILABLE DATA. UNIT COST MEAN AVERAGE MONTHLY COSTS. EXCLUDES ICF/MR.

ASSUMES A 20% MISSISSIPPI STATE GENERAL FUND MATCH RATE TO MEDICAID AFTER SUBTRACTION OF MISSISSIPPI COUNCIL ON AGING FUNDING.

Table 6 takes the data in Table 5 and projects 5 years into the future. This is accomplished by applying an inflation rate of 11.85 percent to all cases in each service category. The rationale for this assumption is that long term care cases will grow at the same rate as the age 75 plus population (based on the United States Census bureau projections). This is usually a fairly safe assumption since the average age of Nursing Home residents is around 82 years in most states, and usually about 77 years in alternative programs. Oregon has been using this method to project future cases for the last ten years with a great deal of accuracy, however, since Mississippi appears to have relative fewer persons over the age of 85 years, this method may be slightly high.

TABLE 6
MISSISSIPPI IN 1994
1988-1989 DOLLARS (NON-INFLATED)
Without changes in current programs*

SERVICE	CASES	UNIT COSTS	TOTAL COSTS	PERCENT OF TOTAL COSTS
AFH	0	$ 0.00	$ 0	0.00%
RCF	0	$ 0.00	$ 0	0.00%
HOME	9,417	$ 58.33	$ 6,591,523	4.44%
N.H.	12,896	$ 916.23	$ 141,788,425	95.56%
TOTAL	22,313	$ 554.16	$ 148,379,948	100.00%

	TOTAL FUNDS	STATE FUNDS
TOTAL COSTS	$ 148,379,948	$ 29,238,061
TOTAL ADDITION 1988-89 DOLLARS	$ 19,410,747	$ 3,837,751
TOTAL GROWTH	15.05%	15.11%

* ASSUMES A 11.85% GROWTH IN AGE 75 PLUS POPULATION AND AN EQUAL AMOUNT IN ALL CASE LOADS. DEFINES CURRENT LEVEL-OF-EFFORT WITHOUT INFLATION. UNIT COSTS MEAN AVERAGE MONTHLY COSTS.

ASSUMES A 10% PER YEAR INFLATION RATE IN NURSING HOMES ABOVE NORMAL INFLATION (EQUALS ABOUT 3.0% TOTAL HIGHER NURSING HOME INFLATION RATE TO MAINTAIN 1988-1989 DOLLARS)

ASSUMES A 20% MISSISSIPPI STATE GENERAL FUND MATCH RATE TO MEDICAID AFTER SUBTRACTION OF MISSISSIPPI COUNCIL ON AGING FUNDING.

Table 6 also does not inflate [illegible] expenditures [illegible] inflation rate for this service. [illegible] level of effort for 1988-1989 to the year [illegible] Dollars. This assumption also forecasts that the percentage of the total elderly population needing long term care services will remain constant (a fairly safe assumption), and that the State of Mississippi is willing and able to serve this increased caseload.

Table 6 indicates that if Mississippi is to serve the same percentage of the population and maintain the same level of effort in 1994 as it does today, then it will need to serve 2,364 additional people, at an additional cost of $ 19,410,747 ($3,837,751 in State General Funds).

Table 7 and Table 8 offer two possible alternative scenarios to the projections made in Table 6.

TABLE 7
MISSISSIPPI IN 1994
1988-1989 DOLLARS (NON-INFLATED)
After the development of Adult Foster Homes*

SERVICE	CASES	UNIT COSTS	TOTAL COSTS	PERCENT OF TOTAL COSTS
AFH	2,500	$ 200.00	$ 6,000,000	4.29%
ACLF	0	$ 0.00	$ 0	0.00%
HOME	9,417	$ 58.33	$ 6,591,523	4.71%
N.H.	11,030	$ 962.04	$ 127,335,614	91.00%
TOTAL	22,947	$ 508.15	$ 139,927,137	100.00%

	TOTAL FUNDS	STATE FUNDS
TOTAL COSTS	$ 139,927,137	$ 27,547,499
TOTAL ADDITION 1988-89 DOLLARS	$ 10,957,936	$ 2,147,189
DIFFERENCE FROM NO-CHANGE	$ -8,452,811	$ -1,690,652
TOTAL GROWTH	8.50%	8.45%

* ASSUMPTIONS SAME AS TABLE 3 EXCEPT: 2,500 CASES ADDED TO ADULT FOSTER HOMES, NURSING HOME CASES DECREASED 500 CASES, AND NURSING HOME UNIT COSTS INCREASED 5% DUE TO LIGHT CARE CASES BEING TRANSFERRED FROM NURSING HOMES TO ADULT FOSTER CARE.

ASSUMES SLIGHT INCREASE IN CASES FROM TABLE 6 (634).

ASSUMES A 20% MISSISSIPPI STATE GENERAL FUND MATCH RATE TO MEDICAID AFTER SUBTRACTION OF MISSISSIPPI COUNCIL ON AGING FUNDING.

TABLE 8
MISSISSIPPI IN 1994
1988-1989 DOLLARS (NON-INFLATED)
After the development of Adult Foster Homes*

SERVICE	CASES	UNIT COSTS	TOTAL COSTS	PERCENT OF TOTAL COSTS
AFH	1,500	$ 200.00	$ 3,600,000	2.51%
ACLF	0	$ 0.00	$ 0	0.00%
HOME	9,417	$ 58.33	$ 6,591,523	4.60%
N.H.	11,530	$ 962.04	$ 133,107,854	92.89%
TOTAL	22,447	$ 531.99	$ 143,299,377	100.00%

	TOTAL FUNDS	STATE FUNDS
TOTAL COSTS	$ 143,299,377	$ 28,221,947
TOTAL ADDITION 1988-89 DOLLARS	$ 14,330,176	$ 2,821,637
DIFFERENCE FROM NO-CHANGE	$ -5,080,571	$ -1,016,114
TOTAL GROWTH	11.11%	11.11%

* ASSUMPTIONS SAME AS TABLE 3 EXCEPT: 1,500 CASES ADDED TO ADULT FOSTER HOMES, NURSING HOME CASES NOT INCREASED, AND NURSING HOME UNIT COSTS INCREASED 5% DUE TO LIGHT CARE CASES BEING TRANSFER FROM NURSING HOMES TO ADULT FOSTER HOMES.

ASSUMES SLIGHT INCREASE IN CASES FROM TABLE 6 (134).

ASSUMES A 20% MISSISSIPPI STATE GENERAL FUND MATCH RATE TO MEDICAID AFTER SUBTRACTION OF MISSISSIPPI COUNCIL ON AGING FUNDING.

Both Table 7 and Table 8 assume that Mississippi has established a viable housing option for long term care, and that this option has been actively pursued. Table 7 and Table 8 are based upon experience in Oregon that showed that about 1,500 Adult Foster Home cases must be established to hold Nursing Cases at a no-growth level, and an additional 1,000 must be established to reduce Nursing Homes about 500 cases. A one for one trade between Adult Foster Homes and Nursing Homes is not possible, because of the latent population in need that will apply for services in Adult Foster Homes, but not in Nursing Homes.

Table 7 shows an increase of $ 10,957,936 ($ 2,147,189 in State General Funds) will be required to maintain long term care after the development of an Adult Foster Home program. However, this is $ 8,452,811 (1,690,652 in State General Funds) less than will be required if no actions are taken (as shown in Table 6). Table 7 also shows that an additional 634 cases will be served.

Table 8 shows an increase of $ 14,660,176 ($ 2,821,637 in State General Funds) will be required to maintain long term care after the development of an Adult Foster Home program. However, this is $ 5,080,571 (1,016,114 in State General Funds) less than will be required if no actions are taken (as shown in Table 6). Table 8 also shows that an additional 134 cases will be served.

A developed Adult Foster Home program will reduce the anticipated size of the nursing home caseload. The amount of that reduction is probably directly related to the amount of effort put into the development of an Adult Foster Home program.

An added benefit of a developed Adult Foster Home program is the utilization of this service by private paying clients. In Oregon, [illegible] percent of [illegible] Adult Foster Home beds are filled with private paying clients. It is since Adult Foster Homes generally set their private rates close to a private client's available resources, the spend down rate is relatively low (only 3 percent in Oregon). Attached to this report for use by Mississippi planners are copies of the Oregon Administrative Rules for Adult Foster Homes, and a recently completed evaluation of the Oregon Adult Foster Home program by Kane and Kane of the University of Minnesota.

ADDITIONAL RECOMMENDATIONS

This report concludes that Mississippi Medicaid has little if any control over the long term care system, and has established cost containment by limiting resources. The report also concludes that if this practice is continued into the future, it will be highly likely that a large number of elderly and disabled Mississippi citizens in need of long term care services will be unable to obtain them.

The report recommends that control be established by two methods: First, a viable Pre-Admission Screening program be created using a reliable and valid assessment instrument, and second, negotiations be established with the Department of Health and the Mississippi Council on Aging to maximize joint efforts in long term care.

The report also recommends that Mississippi establish a viable housing option for its citizens. The report recommends that an Adult Foster Home program be created and that current Nursing Home clients be reviewed for possible relocation to that program. Two additional recommendations are made:

Eligibility

The 2176 Home and Community Based Care Waiver program allows for institutional eligibility (up to 300 percent of the SSI standard) to be applied to community programs. Mississippi has chosen not to apply this higher standard. It is recommended that Mississippi amend its 2176 Waiver to allow for the higher standard.

This recommendation will not increase costs, since Mississippi has limited the total number of slots to be used in the 2176 Waiver, and the report recommends continuing that practice in the future. Currently 71.9 percent of Nursing Home clients in Mississippi would be eligible for services in the community. This means that 28.1 of the Nursing Home clients would not be eligible in the community because their income is above the current community standard. For this group of people an institutional bias has been created: i.e. they are eligible for services in the Nursing Home but not in the 2176 Waiver community programs.

Social Service Block Grants

Interviews with representatives of the Mississippi Council on Aging revealed that about 3.0 million in Social Service Block Grant funds were available to that agency. It is recommended that the Division of Medicaid work with the Council on Aging to devise a method for using this source of funds to draw down additional Medicaid dollars.

While Social Service Block Grant funds cannot be directly used as State match for Medicaid, it is entirely feasible to trade these funds with another state agency for State General Funds, which then can be used for State match. This could increase funding for both agencies without increasing the State General Fund expenditure.

Social Service Block Grant funds can be expended for most Human Resource programs without limitation. If a State agency could be identified that is expending unmatched State General Funds on a particular program, then these funds could be replaced with Social Service Block Grant Funds. If the Council on Aging were to trade that agency on a two for one basis (one State General Fund dollar for every two dollars of Social Service Block Grant funds), that would double the amount the other agency had available to spend on its program, and leave the Council on Aging with 1.5 million in State General Funds. These dollars could then be used to match 6.0 million in federal Medicaid funds, giving the Council on Aging a total of 7.5 million (or 4.5 million more) to spend on long term care.

SUMMARY

Sometime in the near future Mississippi policy makers will have to make some very important decisions regarding long term care. With an estimated 11.85 percent increase of elderly needing long term care expected in the next five years, and an even greater increase expected in the five years after that; Mississippi will most likely have to decide on one of three options:

- Provide long term care services under the present long term care system, and expend a conservative, additional estimated $ 19,410,747 ($ 3,837,751 in State General Funds), due primarily to increased nursing home growth, or
- Decide to continue the moratorium on nursing home growth, without increasing the growth of alternative programs, thereby refusing to serve increasing numbers of its citizens in need of long term care services, or
- Provide services in a more balanced long term care system with less emphasis on nursing homes and more emphasis on alternative services.

Despite, which option Mississippi chooses, it can expect to spend more money on long term care. If Mississippi chooses not to abandon large numbers of its citizens (the second option), then it must either choose to provide services as they are presently structured (the first option), or to make changes to the long term care program (the third option). This report strongly advocates the third option.

STATEMENT OF

GEORGE R. HOLLAND

MR. CHAIRMAN

GOOD MORNING. I AM PLEASED TO BE HERE TO DESCRIBE THE HEALTH CARE FINANCING ADMINISTRATION'S EFFORTS TO ENSURE THAT MEDICARE BENEFICIARIES HAVE ACCESS TO NECESSARY HEALTH CARE.

THE ELDERLY ARE A UNIQUE GROUP WHEN DISCUSSING ACCESS TO HEALTH CARE SERVICES. COMPARED TO OTHER AGE GROUPS, INDIVIDUALS WHO ARE 65 YEARS OR OVER ARE RELATIVELY WELL INSURED -- MORE THAN 95 PERCENT OF THESE INDIVIDUALS ARE COVERED BE MEDICARE AND 70 PERCENT HAVE SUPPLEMENTAL HEALTH INSURANCE COVERAGE THROUGH MEDIGAP POLICIES.

HCFA SUPPORTS SEVERAL INITIATIVES TO IMPROVE THE ABILITY OF THE MEDICARE ELDERLY TO GET THE CARE THEY NEED. WE SEEK TO ACCOMPLISH THIS IMPROVEMENT IN ACCESS BY PROVIDING POSITIVE INCENTIVES TO PROVIDE CARE ONLY WHEN NECESSARY AND AT THE APPROPRIATE LEVEL.

ACCESS TO PHYSICIAN SERVICES

THE PHYSICIAN PAYMENT REFORM ENACTED IN 1989 IS INTENDED TO MAKE MEDICARE PHYSICIAN REIMBURSEMENT MORE EQUITABLE ACROSS SERVICES. UNDER THE NEW PHYSICIAN FEE SCHEDULE, WHICH WILL BE IMPLEMENTED BEGINNING JANUARY 1, 1992, PAYMENTS TO PRIMARY CARE PHYSICIANS WILL INCREASE, RELATIVE TO SPECIALISTS. THIS PROVIDES AN INCENTIVE TO PROVIDE BASIC PRIMARY CARE AND SHOULD IMPROVE ACCESS TO THOSE SERVICES.

IN ORDER TO IMPROVE ACCESS TO PHYSICIAN SERVICES IN MEDICALLY UNDERSERVED AREAS, MEDICARE PAYS PHYSICIANS IN THESE AREAS A BONUS OF 10 PERCENT TO PROVIDE SERVICES TO MEDICARE BENEFICIARIES. MISSISSIPPI HAS 88 AREAS DESIGNATED AS MEDICALLY UNDERSERVED. THERE ARE APPROXIMATELY 517 PHYSICIANS IN MISSISSIPPI WHO ARE ELIGIBLE FOR THIS BONUS.

BENEFICIARIES ARE ALSO ENCOURAGED TO SAVE MONEY ON PHYSICIAN SERVICES BY RECEIVING THEIR CARE FROM MEDICARE PARTICIPATING PHYSICIANS. THESE PHYSICIANS ACCEPT MEDICARE APPROVED CHARGES AS THE TOTAL PAYMENTS FOR SERVICES. NONPARTICIPATING PHYSICIANS ARE PAID A REDUCED AMOUNT OF THE APPROVED PAYMENT.

PHYSICIAN PARTICIPATION RATES HAVE INCREASED EVERY YEAR SINCE THE INCEPTION OF THE PROGRAM. THE NATIONAL PARTICIPATION RATE IN 1990 WAS 47 PERCENT. MISSISSIPPI HAD A SLIGHTLY HIGHER PHYSICIAN PARTICIPATION RATE AT 38 PERCENT IN 1990. THIS WAS A 13 PERCENT INCREASE FORM 1989 AND WE EXPECT TO SEE AN ADDITIONAL INCREASE THIS YEAR WHEN RATES ARE AVAILABLE LATER THIS MONTH.

THE NUMBER OF PHYSICIAN BILLS PAID UNDER ASSIGNMENT, THAT IS ACCEPTANCE OF THE MEDICARE APPROVED AMOUNT AS PAYMENT IN FULL, IS AT AN ALL TIME HIGH. IN FISCAL YEAR 1990, MORE THAN 81 PERCENT OF PHYSICIAN BILLS WERE PAID UNDER ASSIGNMENT, RELIEVING BENEFICIARIES FROM THE FINANCIAL BURDEN OF BALANCE BILLING.

ACCESS TO HOSPITAL SERVICES IN RURAL AREAS

WE HAVE IMPLEMENTED SEVERAL PROVISIONS TO ENSURE HOSPITAL CARE I: AVAILABLE IN RURAL AREAS. SINCE 1988, RURAL HOSPITALS HAV: RECEIVED LARGER MEDICARE PAYMENT INCREASES THAN URBAN HOSPITALS. NEVERTHELESS, THESE HOSPITALS GENERALLY ARE MORE FINANCIALL: VULNERABLE THAN THEIR URBAN COUNTERPARTS DUE TO DECLINING OCCUPANC: AND OTHER ECONOMIC FACTORS.

TO PROTECT THE FINANCIAL STABILITY OF RURAL HOSPITALS , HCFA IS PHASING-IN A SINGLE, NATIONAL PAYMENT AMOUNT TO REPLACE THE SEPARATE URBAN AND RURAL MEDICARE STANDARDIZED AMOUNTS WHICH IS TO BE COMPLETED BY 1995.

MEDICARE ALSO MAINTAINS ITS SPECIAL TREATMENT OF RURAL REFERRAL CENTERS AND SOLE COMMUNITY HOSPITALS. THESE HOSPITALS RECEIVE HIGHER PAYMENT TO PROTECT THEIR UNIQUE STATUS AS PROVIDERS IN THEIR COMMUNITIES. IN MISSISSIPPI, 11 HOSPITALS ARE DESIGNATED RURAL REFERRAL CENTERS, WHILE 2 ARE SOLE COMMUNITY HOSPITALS.

RECONFIGURING RURAL HOSPITAL SERVICES

HCFA IS ALSO WORKING TO ASSIST RURAL COMMUNITIES IN RECONFIGURING THEIR HEALTH CARE DELIVERY SYSTEMS. WE ARE IN THE PROCESS OF IMPLEMENTING THE OBRA 89 PROVISIONS TO DESIGNATE CERTAIN RURAL HOSPITALS AS ESSENTIAL ACCESS COMMUNITY HOSPITALS AND RURAL PRIMARY CARE HOSPITALS. THIS DESIGNATION WILL OFFER ASSISTANCE TO STATES IN ASSURING THE AVAILABILITY OF EMERGENCY TREATMENT SERVICES IN RURAL AREAS WHERE IT IS NOT FINANCIALLY FEASIBLE TO MAINTAIN A FULL SERVICE HOSPITAL. APPLICATIONS WERE SENT OUT AT THE END OF JANUARY. WE EXPECT TO HAVE APPLICATIONS RETURNED BY MAY 1, 1991, AND TO MAKE AWARDS BY SEPTEMBER.

IN ADDITION, WE HAVE AWARDED A SECOND ROUND OF RURAL HEALTH TRANSITION GRANTS THAT WILL HELP SMALL, RURAL HOSPITALS MODIFY THEIR SERVICES TO ADJUST TO MARKET CONDITION AND COMMUNITY HEALTH NEEDS. WE BELIEVE THAT DIVERSIFICATION OF SERVICES TO BETTER MEET THE COMMUNITY'S NEEDS WILL HELP RURAL HOSPITALS SURVIVE.

A TOTAL OF 394 TRANSITION GRANTS AND $25.1 MILLION HAVE BEEN AWARDED TO DATE. MISSISSIPPI HAS RECEIVED 9 GRANTS WORTH OVER $575,000.

PROPOSED CAPITAL REGULATION

HCFA HAS RECENTLY PUBLISHED PROPOSED REGULATIONS FOR FOLDING CAPITAL PAYMENTS INTO THE PROSPECTIVE PAYMENT SYSTEM (PPS) FOR HOSPITALS. BY LAW, MEDICARE IS REQUIRED TO DO THIS BEGINNING OCTOBER 1, 1991. WHEN FULLY IMPLEMENTED, THE CAPITAL PPS WILL PROVIDE HOSPITALS WITH A FIXED AMOUNT FOR EACH MEDICARE ADMISSION AND WILL ESTABLISH A SINGLE NATIONAL RATE, REGARDLESS OF WHETHER A HOSPITAL IS RURAL OR URBAN. A CAPITAL PPS WILL ENCOURAGE HOSPITALS TO MAKE PRUDENT CAPITAL DECISIONS.

MANY ARE CONCERNED ABOUT THE IMPACT OF THE PROPOSED REGULATION ON RURAL HOSPITALS. ESTABLISHING A FEDERAL RATE BASED ON THE AVERAGE CAPITAL SPENDING FOR ALL HOSPITALS RESULTS IN LOW-COST HOSPITALS RECEIVING A HIGHER CAPITAL PPS PAYMENT THAN UNDER THE CURRENT COST SYSTEM. BECAUSE THE MAJORITY OF RURAL HOSPITALS HAVE CAPITAL COSTS BELOW THE NATIONAL AVERAGE, THEY ARE LIKELY TO FARE WELL UNDER THE PROPOSED CHANGE, AS LONG AS THEY CONTINUE TO MAKE PRUDENT CAPITAL INVESTMENTS.

TO AID HOSPITALS WITH CAPITAL COSTS ABOVE THE NATIONAL AVERAGE THE REGULATION INCLUDES AN EXCEPTIONS POLICY TO PROVIDE ADDITIONAL PAYMENT FOR COSTS IN EXCESS OF 150 PERCENT OF THE PAYMENT. THERE IS ALSO A GENEROUS EXCEPTIONS POLICY FOR RURAL SOLE COMMUNITY HOSPITALS.

COORDINATED CARE

WE CONTINUE TO SEEK BETTER CARE AND BETTER VALUE FOR OUR HEALTH DOLLARS IN THE MEDICARE PROGRAM. COORDINATING CARE CONSERVES SCARCE HEALTH RESOURCES BY PROVIDING ONLY NECESSARY CARE, THEREBY CONTAINING HEALTH COSTS. CURRENTLY, MEDICARE HAS ABOUT 1.25 MILLION BENEFICIARIES ENROLLED IN RISK HEALTH MAINTENANCE ORGANIZATIONS (HMOs) NATIONALLY. ALTHOUGH NO MISSISSIPPI MEDICARE BENEFICIARIES ARE ENROLLED IN RISK HMOs, WE SEE THIS AS A POTENTIAL AREA OF EXPANSION IN THE FUTURE.

COORDINATED CARE PLANS, SUCH AS HMOs AND COMPETITIVE MEDICAL PLANS (CMPs) PROVIDE QUALITY CARE AT AN AFFORDABLE PRICE. MEDICARE BENEFICIARIES WHO JOIN COORDINATED CARE PLANS USUALLY HAVE LESS OUT-OF-POCKET COSTS THAN FEE-FOR-SERVICE, BECAUSE HMOs AND CMPs GENERALLY HAVE SMALLER COINSURANCE PAYMENTS WHICH ARE MORE PREDICTABLE. IN FACT, SOME PLANS ALSO OFFER BENEFITS WHICH ARE NOT COVERED BY MEDICARE FOR LITTLE FOR NO ADDITIONAL COST, SUCH AS PREVENTIVE CARE AND DENTAL CARE.

THE PRESIDENT'S BUDGET INCLUDES A $40 MILLION COORDINATED CARE INITIATIVE FOR FY 1992 AND $1.4 BILLION OVER FIVE YEARS. THE INITIATIVE IS DESIGNED TO STRENGTHEN THE EXISTING MEDICARE COORDINATED PROGRAM AND EXPAND OPTIONS AVAILABLE TO BENEFICIARIES. WE BELIEVE THAT SUPPORTING COORDINATED CARE IS A WISE INVESTMENT IN THE FUTURE OF THE MEDICARE PROGRAM IN ORDER TO CONTINUE FINANCING HIGH QUALITY HEALTH CARE FOR BENEFICIARIES.

ACCESS TO CARE AND LONG TERM CARE

WE ARE ALSO LOOKING AT THE LARGER QUESTION OF ACCESS TO HEALTH CARE AND LONG TERM CARE. THE IMPORTANCE OF THIS ISSUE IS EVIDENCED BY THE NUMBER OF GROUPS ESTABLISHED TO ADDRESS THESE PROBLEMS AND RECOMMEND SOLUTIONS.

THE U.S. BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE -- THE PEPPER COMMISSION -- HAS ALREADY ISSUED ITS REPORT OF FINDINGS, AND THE SOCIAL SECURITY ADVISORY COUNCIL IS ALSO EXPECTED TO COME FORTH WITH ITS RECOMMENDATIONS. THE NATIONAL GOVERNORS ASSOCIATION HAS DESIGNATED HEALTH CARE REFORM AS ITS NUMBER ONE PRIORITY FOR THIS YEAR AND IS CONDUCTING A STUDY THAT IS EXPECTED TO BE COMPLETED BY AUGUST 1991.

A SPECIAL DEPARTMENTAL TASK FORCE IS ALSO CHARGED WITH EXPLORING SOLUTIONS TO PROBLEMS OF HEALTH CARE ACCESS, EQUITY, AND COST. HCFA ADMINISTRATOR GAIL WILENSKY SERVES AS VICE-CHAIR OF THE TASK

FORCE. THE MISSION OF THE TASK FORCE INCLUDES A THOROUGH ANALYSIS OF LONG TERM CARE ISSUES AND OPTIONS FOR FINANCING INITIATIVES.

CONCLUSION

MR CHAIRMAN, HCFA SUPPORTS MANY PROGRAMS WHICH ARE INTENDED TO IMPROVE BENEFICIARY ACCESS TO PHYSICIAN AND HOSPITAL SERVICES, MAINTAIN SERVICES IN RURAL AREAS, AND EXPAND ACCESS TO COORDINATED CARE. WE ALSO CONTINUE TO SEEK A COMPREHENSIVE SOLUTION TO THE PROBLEM OF ACCESS TO CARE FOR THE ELDERLY.

THANK YOU. I AM HAPPY TO ANSWER ANY QUESTIONS YOU MAY HAVE.

Prepared Statement of Bill Shakelford

Access to Health Care for the Elderly

Clarksdale, Mississippi

May 1, 1991

What is being done now to address barriers to access and what more should be done?

Three issues are primary to the access of health care:

- availability of health care services,
- financing (paying for) health care services, and
- information/education.

The barriers in Mississippi as relates to these issues vary depending on the region of the state, population demographics and socio economic conditions.

Private Insurer Perspective

With Medicare as the primary payor of acute health care expenses for the elderly since 1966, the private insurance industry has been responsible and taken the position of a secondary payor supplementing those expenses not covered by Medicare.

With the continuing rise in health care costs, the out of pocket expenses since the inception of the Medicare program have likewise increased. Based on a report in 1990 by the House Committee on Aging, out of pocket costs paid by the elderly, however, are growing at a rate higher than that amount paid by Medicare or Medicaid and the trend

shows no sign of slowing. Elderly out of pocket costs for health care were 12.3% of income in 1977 and have risen to an estimated 20% of income today. This is shifting an additional responsibility on the private insurer to meet the Medicare eligibles' need for coverage of costs not paid by Medicare. In Mississippi, there are currently 345,000 individuals 65 or older. In addition to a continuing increase in health care costs, our population is aging and people are living longer. In the next 30 years, the population nationwide age 65 and older is projected to increase by 50% and the population age 85 and over is projected to triple.

As a result, long term care beyond the acute care stage must be a priority of our health care system in terms of availability of services and financing those services.

For these reasons, Blue Cross & Blue Shield of Mississippi is presently involved in a comprehensive study to assess its current product and service offerings to the elderly in Mississippi. This study will define our cooperative strategy for the future which is part of our corporate goal to provide affordable health care to all Mississippians.

Medicare Supplement Coverage

A number of private carriers offer Medicare Supplement benefits. For the most part, these benefits cover the Medicare Part A and Part B deductibles and coinsurance. Blue Cross & Blue Shield of Mississippi and AARP (Prudential) are the two major companies offering such coverage in Mississippi. Data estimates show that 272,920 Mississippians (Non-Medicaid eligible) are Medicare eligible. Of these, 132,698 have some form of private insurance and Blue Cross & Blue Shield of Mississippi insures 31%. This leaves 140,222 with no private insurance. Nationally, it is estimated that 70% of the Medicare eligible population has some form of supplement insurance. Mississippi data indicates that on an average less than 50% have private insurance.

Blue Cross & Blue Shield of Mississippi provides a range of Medicare Supplement products available to Medicare eligibles. The products supplement Parts A and B of Medicare and have optional coverage for prescription drugs and nurses. These products and rates are regulated by the Commissioner of Insurance. On a financial basis, the products performed poorly in 1990 with a 94% loss ratio, primarily due to the prescription drug components and inadequate rate relief.

Private insurance Medicare Supplement coverage is critical to health care financing for the elderly in Mississippi. Therefore, efforts are underway to ensure the quality of the products while maximizing access.

In conjunction with the Mississippi Insurance Commissioner's office, Blue Cross & Blue Shield of Mississippi is enhancing its Medicare Supplement program based on a new rating structure and benefit designs.

As part of this benefit enhancement, programs are also being developed to provide value added coverages at reduced costs for vision care, hearing, dental, prescription drugs, etc.

On a National level, working through the Blue Cross and Blue Shield Association, there is direct involvement in support of the Medicare Supplement reform standardization activities (OBRA-90).

These standards are in an effort to improve the quality of Medicare Supplement policies and increase access through benefit design and underwriting policies, etc.

Even with emphasis on ensuring the quality of Medicare Supplement product offerings, affordability continues to be the issue, especially in Mississippi. Therefore, efforts must continue as to innovations in financing and cost containment for Medicare Supplement benefits.

Long Term Care

Medicare covers care in skilled or intermediate facilities typically associated with acute care or recovery from hospitalization. Medicare was not intended to cover long term care. Therefore, long term care benefits are the single biggest health care financing problem for the elderly.

Today Long Term Care can be financed by:

- Medicare, available only for needs associated with an acute condition,
- Personal income or savings,
  (this is limited in Mississippi due to income levels)

- Medicaid, available only if the individual (spouse, if any) spends down his, her or their assets to a specified level,
- Private insurance
  (This coverage has become available only recently on a limited basis.)

Currently, according to the American Academy of Actuaries, long term care expenses total $50 billion annually, with 50% paid by individual savings, 45% by Medicaid and the balance by Medicare, private insurance or some other government service.

It is estimated that the aging population, along with improvements in medical technology and impact of inflation will result in total long term care expenses nationally in the year 2000 of approximately $225 billion.

These statistics point out a serious need for long term care coverage for the elderly.

- It is important that private insurance play a major role in financing Long Term Care for senior citizens who need it without forcing them to face economic catastrophe.
- Private Long Term Care coverage is relatively new but has grown rapidly. In 1986 there were only 130,000 Long Term Care insurance policies sold with more than 1.15 million sold by the end of 1990.

Currently one half of the Blue Cross and Blue Shield Plans offer Long Term Care policies and Blue Cross & Blue Shield of Mississippi is developing a product, offering it through its Life Insurance Agency.

With extensive input from consumer advocates and the private insurance industry, NAIC has established long term care standards. These standards should allow for sufficient flexibility for the Long Term Care market to grow and develop. There is a concern that federal standards that go beyond the NAIC standards could hamper growth and affordability in the market.

It is important to note that supplemental (Medigap) insurance and Long Term Care are different in their objectives. Medigap provides supplemental insurance to the Medicare program. Long Term Care is not tied to this Federal program and therefore must be viewed differently.

If Federal legislation is felt necessary, it should incorporate the standardization developed by the NAIC. This would ensure that efforts to protect consumers who buy private Long Term Care are protected based on the expertise of the nation's insurance commissioners. However, it is also important that states adopt and adequately enforce these regulations. There are also several tax incentives that could encourage growth in this type protection to those who could afford such coverage.

- Tax exclusion for employer-provided long term care benefits

  Specifically, benefits paid out and employer contributions for Long Term Care would be excluded from an employee's income.

- Individual Deductions

  Individuals would be permitted to deduct qualified Long Term Care expenses and premiums using the limited medical expense deduction allowed with Section 213 of the Internal Revenue Code.

- Calculation of Long Term Care Insurance Reserves

  Insurers could be allowed to establish long term care reserves on a tax favored basis after the insurance has been in force for one year to allow insurers to keep premiums as low as possible.

rmation/Education

ther element critical to health care for the elderly is appropriate and available cation and information - not only of health care benefits and issues - but healthy tyles.

a national level, AARP has taken a leadership role in providing such information to nembers.

Toward this goal in Mississippi many communities have established activities through elderly clubs or hospital programs, etc. to assist the elderly in information exchange and establish health and wellness programs. In 1991, Blue Cross & Blue Shield of Mississippi is developing a service program dedicated specifically to its elderly Subscribers (age 65 and older) that will extend beyond our service center into the communities throughout Mississippi. This will allow us to communicate and work directly with the elderly on benefit issue and health issues that are unique to this segment of our population.

Managing Care for the Elderly - A Cooperative Effort

The health care needs of the elderly become more costly with age. However, preventive action can be effective with the elderly as with the younger population. A good diet, proper exercise, low stress and periodic medical checkups can lead to a longer healthier life.

Young population may have access to Managed Care programs (wellness programs, PPOs, HMOs, etc.) to help manage their health care, however, Medicare generally has had no such program. Medicare's Select (PPO) program is in the development phase and private insurance in selected states will have an opportunity to extend some private section managed care to the elderly.

As the health care needs of the elderly increase and the number of elderly increases in Mississippi, we will need more availability of services and providers beyond the hospital and physician office settings, where preventive, acute, long term and social services are integrated.

At present, in certain areas of the state provider availability is limited as is necessary transportation to access these services. This is a social issue that can only be addressed through a statewide cooperative effort.

The elderly are a valued and ever growing segment of our population. Their health care needs now and in the future as relates to education, services, and financing are unique and must be addressed as such.

To properly address and ensure health care access for the elderly, private insurers must work in a coordinated effort with providers, the communities, and the government.

Prepared by

Blue Cross & Blue Shield of Mississippi, Inc.

MISSISSIPPI DEPARTMENT OF HUMAN SERVICES
DIVISION OF AGING AND ADULT SERVICES
COUNCIL ON AGING

The graying of America, including the intensive growth of older Mississippians has many implications for the changing needs of health care for the elderly in this State. With an increase in longevity comes an increased need for acute and chronic (long term) health care. However, the cost of these services is devastating for many seniors in Mississippi who have fixed, low or moderate incomes. As the national and state health care systems grow more costly each year, the number of elderly and poor who need care cannot afford the cost of care. This trend can be expected to continue until health care cost is brought under control and made accessible for all individuals.

In addition to the increased cost of public health care, in general, there has been a rapid increase in medical costs for the elderly, in particular. These high costs coupled with the increasing number of individuals without health care coverage is straining the system's capacity to provide care for the elderly who may not be able to pay. To complicate this situation, congress has proposed a budget that would increase the deductible and co-payment under the Medicare program. Under one plan, older individuals with incomes of $25,000 or more and couples earning $32,000 or more would pay a higher premium for Part B than other beneficiaries. An analysis of this proposal indicates that this would increase the out-of-pocket cost of Medicare, Part B by $27 million over five years and the co-payment would increase to thirty percent over the same period of time. If such proposed policy becomes law, approximately 326 thousand Mississippians 65 years of age and older will be affected. Many of these individuals' benefits will become so inadequate that they will be forced to either forego needed treatment or use their life savings to pay for a catastrophic illness.

In the most recent years, health care professionals, advocates and Congress have focused their attention on hospital and health care cost containment. Similarly, private insurance plans have adopted programs that focus on limited hospital or physician

reimbursement through set fees, increased competition and alternative delivery mechanisms. All such actions have and will continue to affect the level of health care available to every elderly person existing on low and moderate incomes. The best scenario that one may expect at the present rate of growth in medical cost and regulatory actions advocated by health care professionals and Congress, is that benefits will be reduced, eligibility will be narrowed and fewer poor and elderly individuals in this State will benefit from health care services.

The elderly are in the highest risk catergory of individuals for long term health care services because there is a higher likelihood of chronic conditions and functional limitations with increasing age. Research shows that two-thirds of the long term care population is the elderly and that the demand for long term health care is increasing. Growth in the numbers of elderly who will most likely need long term health care makes improvements in the nation's financing of this care imperative for the well being of all elderly Mississippians.

If disability rates remain what they are today, the number of elderly persons needing help with basic tasks is expected to double between 1990 and 2030, increasing from about seven million to almost 14 million. The number of elderly requiring nursing home care is expected to more than triple, rising from about 1.5 million to over five million; the use of high technology and new medical breakthroughs will no doubt continue to extend the lives of disabled people of all ages. It is highly unlikely that service availability will keep up with the growing needs of health care. Demographic trends predict that fewer family members will be available to care for their disabled relatives. The private marketplace will be challenged to develop an adequate home care delivery system, even for those who can pay. The two major public programs, Medicare and Medicaid, have structural limitations that will prevent them from meeting all the projected needs of the poor and elderly.

Without changes in public policy, more and more Americans, including Mississippi's elderly, will have difficulty accessung the

care they need in nursing homes as well as in-home. The Council on Aging firmly believes that we will have to strike a greater balance in funding institutional and in-home services. We further believe that community based care or non-institutional care will become a more appropriate way of meeting the long term health care needs of those most likely to suffer from chronic illnesses, such as the elderly.

Many rural communities and small towns in Mississippi experience greater difficulty in recruiting health care professionals to serve individuals in those areas. While the number of physicians has increased recently in the more populated rural communities, it is expected to decline in the less populated areas due to a projected 25 percent rate of physician retirement in rural areas and severe cutbacks in the National Health Service Corps (NHSC) Program, which provides physicians to rural communities. The problem of too few providers in rural areas is compounded by a general decline in the growth of primary care doctors, who are uniquely suited for rural practice and the shortage of nurses and other midlevel practitioners in rural areas. Many rural hospitals that serve the elderly and the poor are closing or in jeopardy of closure because of financial constraints and the availability of professionals who are willing to practice in rural communities.

Even if the elderly's health care is paid for, those in poverty may experience other significant logistical barriers to care. For those who cannot afford to maintain a car, take public transportation or pay taxicab or a friend, travel to medical care is a serious problem. When public transportation is available and affordable, the effort required to get from home to the source of care may be extraordinary.

There are other nonfinancial barriers that often result in the elderly accessing care too late or less often than needed. As a result their medical conditions become more severe and require more

acute and costly treatments. These may include access by elderly living in medically under served areas such as rural communities or isolated locations, and elderly members with special needs such as the mentally or physically handicapped.

The mentally ill or retarded elderly individuals may not have the skills necessary to negotiate the health care system, such as making an appointment, arranging transportation or getting a prescription filled. Some may not recognize their need for treatment. Those who do not have a friend or relative to assist them or urge them to seek care may go untreated, or may fail to comply with prescribed treatments. Experience shows that medical care cannot be fully accessible and effective for such individuals unless it is accompanied by education and outreach and by other systems which coordinate a broad range of services.

In summary, it is the opinion of the State Unit on Aging that as the growth of the older population of this state continues, more older people, especially the very old, 85 years of age and over, are likely to suffer from chronic illnesses and therefore have a greater need for long term health care. Some professions may speculate that medical advances could reduce the elderly's need for care, but it is conceivable that longer lifespans could also increase this need. We also believe that if disability rates remain what they are today, the number of elderly Mississippians needing help with basic activities of daily living will increase, thus, requiring greater nursing home care, and more ideally in-home assistance. Based upon these life changes, the rising cost and availability of health care services along with limited professionals in medically under served areas in Mississippi, the Mississippi Department of Human Services, Division of Aging and Adult Services, Council on Aging offers the following recommendations to access health care:

- That governmental subsidized program regulations be reviewed to determine how a more equitable cost sharing health care system can be implemented so that there will be a level of health care available for all citizens including the elderly.

- That federal, state and local governments along with the private sector join forces to develop and fund health care programs that will realistically address the true cost of health care for the uninsured and underinsured elderly populace of this state and nation.

- That governmental agencies such as the Administration on Aging, The Public Health Service and the U.S. Department of Housing and Urban Development develop a strategic plan for initiating, implementing and funding coordinated supportive and health services in public congregate housing and other subsidized housing programs. Such efforts would provide health clinics and senior center services in housing sites and would provide health prevention, promotion and treatment during the early stages of a health related illness that may become acute or chronic. These health centers could be staffed and operated by a local community hospital.

Basic Health Conditions of the Elderly and Associated Cost for Treatment

Conditions	Medical Treatments	Cost For Treatment
		(1st year)
Heart Disease	Coronary By-pass Surgey	$ 30,000
Cancer	Lung Treatment Cervical Cancer	$ 29,000 $ 28,000
Stroke	Hemiplegia Treatment and Rehabilitation	$ 22,000
Injuries	Qaudriplegia Treatment And Rehabilitation	$ 570,000 (Lifetime treatment)

Adapted from :Healthy People: National Health Promotion and Disease Prevention objectives."

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STATE OF MISSISSIPPI

RAY MABUS
GOVERNOR

May 2, 1991

Honorable Thad Cochran
United States Senate
326 Russell Senate Office Building
Washington, D.C. 20510

Dear Senator Cochran:

Thank you for affording me the opportunity to participate in the field hearing yesterday in Clarksdale. I am now writing to add a short note to the record clarifying two points that were raised by other speakers.

First, is the statement made by Martha Carole White that Medicaid reimbursement does not permit nursing facilities to pay the same salaries to nurses as hospitals. If there is a difference in salaries, it has nothing to do with reimbursement, as the methodology is the same for both and consists of computing a per diem based on actual cost. Any differences cannot be attributed to Medicaid, but rather must be explained by differences in special qualifications or merely the market. Another possible explanation may be found in different reimbursement methodologies between Medicaid and Medicare.

Second, is the point raised by Mary Pat Curtis dealing with reimbursement to nurse-practitioners. Certain specialties within the nursing profession have been recognized by the Licensing Board, and nurses with appropriate additional training may be certified as nurse practitioners in that area. Gerontology is not yet such an area in Mississippi. Ms. Curtis also raised the point that although nurse-practitioners' services are reimbursed by Medicaid, they are identified to our system through the supervising physician, and the costs are lumped together. For this reason, we cannot now derive an accurate picture of the activity and comparable costs of physicians to nurse-practitioners. The Division of Medicaid hopes to correct this when we implement our new Medicaid Management Information System next January.

I would appreciate your making these notes a part of the record of your field hearing on "Access to Health Care for the Elderly," and thank you again.

Sincerely yours,

Helen Wetherbee

Helen Wetherbee, J.D., M.P.H.
Director, Division of Medicaid
Office of the Governor

HW:kgw

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HENDERSON DRUG AND HOME HEALTH CARE CENTER
270 DELTA AVE PO BOX 819
CLARKSDALE MS 38614

"ACCESS TO HEALTH CARE FOR THE ELDERLY"

Senator Cochran:

My name is Shirley Kidd. I spoke with you briefly at the Senate Subcommittee Hearing on "Access to Health Care For the Elderly" May 1, 1991 in Clarksdale MS. You ask that I send this information to you. I think after reading it you will understand the problems we are facing as Home Medical Equipment (HME) suppliers, and make this a part of the Offical Senate Committee Record.

I am writing to bring to your attention the devastating impact on access to quality home care services for Medicare beneficiaries which may result from the Health Care Financing Administration's (HCFA) implementation of new Home Medical Equipment fee schedules. Henderson Drug and Home Health Care Center supplies HME products and services to people with disabilities and elderly patients for their use in the home, and was founded on the desire to provide the highest level of service possible.

As you may know, HCFA recently developed new fee schedules and instructions to implement the numerous changes to HME Medicare reimbursement resulting from OBRA 1990. Our preliminary analysis of these changes indicates that cumulative payment reductions for most equipment will be in the range of 30-50 percent. In some cases, the new fee falls below acquisition costs. While some HME suppliers operate on a national level, the majority are small businesses which already have experienced extreme reductions of over 40 percent for certain items of equipment in recent years. Yet, despite the fact that HME accounts for only 2 percent of the overall Medicare budget, this industry is now confronted with additional reimbursement reductions.

Medicare carriers implemented these changes on May 1, 1991 without the benefit of even the minimum 30-day transition period that is customary for virtually all similar HCFA mandates. Moreover, some Medicare carriers have indicated that it will be impossible for them to implement changes of this magnitude by May 1, thereby resulting in inconsistent and potentially confusing "piecemeal" implementation across the country.

As an HME supplier in Mississippi, I am very concerned about the long term effects of these Home Medical Equipment reimbursement reductions, particularly as they relate to my ability to continue providing quality medical equipment supplies and services to Medicare beneficiaries. I am aware of the need for fiscal restraint in the area of Medicare spending; however, it makes little sense to systematically erode and dismantle the very industry that allows individuals to recuperate from an injury or illness at home, usually for far less cost than similar care provided in an institution.

Reimbursement reductions that approach 50 percent for some items of HME clearly exceed Congress' intent in enacting OBRA 1990. Given the numerous known problems with the HCFA data used to calculate the 1991 fees—including inaccurate fees, insufficient available information with which to determine correct pricing information and inconsistencies in application—this data and the methodology used for its calculation should be subject to close and careful scrutiny prior to any implementation of the new fee schedules.

These reductions may severely affect the ability of some HME suppliers to continue to provide the high levels of service to their customers they are accustomed to having. Some suppliers may not be able to continue operating in their present capacity. The very real potential thus exists for numerous business closures, resulting not only in the loss of employment opportunities, but also curtailed access to needed medical care for Medicare beneficiaries. In all cases, not only are businesses and the economy harmed by these actions,

but also, so are the ultimate recipients of HME services, the elderly and disabled. I do not want Henderson Drug and Home Health Care Center to be forced to cease providing certain HME products and services to our patients and clients. Home care is the most effective, efficient, and compassionate way to provide needed care. HME plays a vital roll in the home health care system by providing a high level of customer service that is individually tailored to meet specific patient needs.

I urge you to consider HME issues as soon as Congress reconvenes, and to enact certain critically needed technical changes and other revisions to the Medicare law as soon as practicable to avoid further erosion of HME suppliers' ability to adequately serve the needs of Medicare beneficiaries.

It is important that our Congressional delegation band together and stand up for the rights of Mississippis' elderly. I know of your dedication to our senior citizens and feel confident that you will take steps to help the people of your state.

Thank you for your support.

Sincerely,

Shirley Kidd

Senator COCHRAN. The hearing is now adjourned.
[Whereupon, at 12:20 p.m., the subcommittee was adjourned.]

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